

CASE LAW UPDATE

2015

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SUPREME COURT AND COURT OF APPEAL CASES

1. AOE/COE

South Coast Framing v. WCAB (Clark)(Supreme Court) 80 C.C.C. 489

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

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

The parties utilized doctor Bruff as an AME. The doctor opined that the applicant died from an interaction of Ambien and Xanax. In deposition the doctor testified that it was possible the Amitriptyline could have contributed to the applicant's death but the Ambien and Xanax "carried the day" but he stood by his initial report.

Based on the AME's deposition testimony the judge determined that the death was work related since the applicant took Amitriptyline as well as Ambien and Xanax. All of these drugs contributed to his death. The board denied recon.

Defendants filed a petition for writ and the court issued an unpublished opinion.

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

The court annulled the Board's order denying recon and remanded with directions to enter a new order denying the claim. Applicant filed an appeal to the Supreme Court that was granted. The Supreme Court found as outlined below.

The Supreme Court reversed the Court of Appeal's decision that the Board had erred in relying on the deposition testimony of the AME to find that the death of an industrially-injured carpenter who overdosed on medications, some of them industrially-prescribed, arose out of the carpenter's employment.

The Supreme Court held that in death cases when death is attributable to both industrial and nonindustrial causes may support a death claim, and industrial causation has been shown in an array of scenarios where a work injury contributes to a subsequent nonindustrial injury."

Whether an industrial injury proximately causes a later injury or death within the meaning of [Lab. Code] section 3600 is a question of fact.

In light of the evidence, the WCJ could reasonably find that Elavil and Vicodin increased the likelihood of death by drug overdose. Under these circumstances, those two drugs could be found to have contributed to Clark's death within the meaning of section 3600. This factual issue was resolved by the WCJ. The evidence on this point was not overwhelming. However, the WCJ resolved the question in favor of the claimant.

The Supreme Court held that the Court of Appeal is not free to reweigh the evidence or substitute an inapplicable standard of review.

The Supreme Court requires applicants to establish no more than that industrial causation is reasonably probable. Injury or death resulting from medical treatment of a work injury is compensable, and this rule applies whether the treatment is provided by a physician selected by the employee or by the employer or the employer's compensation carrier. It is within the Legislature's exclusive province to specify the causation standard required for compensation. The Legislature has not articulated a more stringent standard for death claims than disability claims. The Supreme Court stated the courts may not break from long-standing precedent to apply a higher proximate cause standard to death cases when the Legislature has not seen fit to do so.

2. Temporary Disability

Larkin v. WCAB (Supreme Court) 80 C.C.C. 1243

Applicant, a salaried peace officer for the City of Marysville sustained injuries to his neck, right shoulder, thigh, face, bicep and nose. He sought TD at a maximum rate regardless of his earnings. Labor Code section 4458.2 provides workers' compensation benefits to certain peace officers injured in the line of duty. The terms of the statute apply to any "active peace officer of

any department as described in Section 3362 who suffers injury or death while in the performance of his or her duties as a peace officer." (§ 4458.2.) The statute likewise provides benefits to those injured while performing services as part of a so-called posse comitatus--a group of citizens convened by law enforcement authorities for certain limited law enforcement purposes, in accordance with section 3366--and to certain reserve peace officers as described in section 3362.5. (§ 4458.2.) The Supreme granted review to determine whether the benefits provided under section 4458.2 extend to both volunteer peace officers and to regularly sworn, salaried officers. At trial the WCJ held that applicant was not entitled to maximum indemnity levels set out in Section 4453. This was upheld by both the WCAB and the appellate court. A petition for review was filed with and granted by the Supreme Court.

The Supreme Court held that through Lab. Code, § 4850, the Legislature has provided a benefit to regularly sworn salaried peace officers--paid leave--available to few other employees. And it has determined that this extra benefit should not deprive regularly sworn peace officers of their eligibility for disability indemnity should their temporary disability last more than one year (Lab. Code, § 4853). Yet by their own terms, these provisions do not apply to volunteers. Given this limitation, Lab. Code, § 4458.2, serves a critical balancing purpose in the statutory scheme. It provides maximum disability indemnity and death benefit installment payments to those volunteer peace officers whose service to their departments entails risks of great magnitude. And it bases those maximum indemnity levels on fictitious earnings. In short, the Legislature has determined that irrespective of actual pay, volunteer peace officers are entitled to maximum indemnity levels in the event of injury or death suffered while performing their duties.

The Court further determined that the applicant was entitled to workers' compensation benefits to the same extent as any other injured employee, that, although Labor Code § 4458.2 does not explicitly preclude its application to regularly sworn, salaried officers, it does explicitly relate availability of its benefits to Labor Code § 3362, whose provisions are evidence that the legislature intended Labor Code § 4458.2 to apply only to volunteer and reserve officers who would not, otherwise, have been covered by workers' compensation, that this conclusion is further supported by Labor Code § 3362's place in the structure of the workers' compensation benefits scheme, which reveals that the legislature determined that, irrespective of actual pay, volunteer peace officers were entitled to maximum indemnity levels in event of injury or death suffered in line of duty, and that the available legislative history associated with Labor Code §§ 3362 and 4458.2 is in accord with the Supreme Court's analysis.

3. Trial Procedure

Ogden Entertainment Services v. WCAB (Von Ritzhoff)(Court of Appeal Published) 80 C.C.C. 1

Applicant sustained an injury to his right ankle, right foot and psyche in March 1996. The matter proceeded to almost 20 years of litigation. The last 12 years were characterized by multiple hearings, medical legal evaluations, problems generated to a great extent by applicant's conduct, including his willingness to testify only when it suited his purposes, refusal to be cross examined, animosity that caused several doctors to discontinue his treatment and evaluation, orders by the WCAB declaring him a vexatious litigant and other irregularities.

The WCJ found applicant to be 100 percent disabled without apportionment based on the opinion of the primary treating physician, Thomas Curtis, M.D. The WCJ also awarded applicant future medical treatment and 12 years of temporary disability based on earnings of \$320 per week.

The defendants filed a petition for reconsideration which was denied by the WCAB. WCAB and the WCJ ruled that though the applicant refused to submit to cross-examination because his testimony would add nothing to the case because the case involved a medical issue. The Court of the Appeal annulled the decision of the WCAB.

The court went through a recitation of the case history, with emphasis on applicant's conduct at four hearings between 2006 and 2013. The court outlined applicant's prior refusals to be cross examined and accusations of judicial misconduct.

The court observed that for two centuries, the Anglo-American evidentiary system has considered testing by cross-examination to be a vital feature of the law, and that no safeguard for testing the value of statements is comparable.

The court cited the case of *Pointer v. Texas* (38 US 400) which held that the right of confrontation and cross-examination is essential to the fair trial that is our constitutional aim.

The right of cross-examination is guaranteed in Worker's Compensation's proceedings. (*Pacific Employers v. IAC* (6 CCC 297 and Government Code 11513 (b))

The court then addressed the misperception shared by the WCJ and the Board that as a layperson applicant had nothing to add as a witness. An important object of the right of confrontation is to guarantee that the finder of fact can assess witness credibility. Witken writes that the chief goal of cross-examination is to ascertain credibility, knowledge, and witness recollection. (3 Witkin California Evidence)

The court indicated that the lack of cross-examination was prejudicial. Cross-examination was not merely curtailed, but except for a few minutes early on, did not take place at all. In this

unusual situation, the litigant was completely deprived of its right of cross-examination. The denial of due process that occurred prevented a fair hearing and is reversible per se.

The court went on to say that the applicant's conduct over the issue of cross-examination was so irregular as to make examination into the question of his credibility practically a necessity. The credibility of a person who is given to manic outbursts of the kind shown by this record is, at a minimum, seriously drawn into question. The wild flights into conspiracy theories, accusations of criminal misconduct and even personal inflected do not necessarily reflect a mind given to an accurate recitation of the facts, particularly facts as complex as those underline psychiatric histories.

The court went on to say they do not presume to render an opinion as to the applicant's credibility, leaving that to the trier fact, it is clear that his very conduct, particularly during the last hearing move that issue center stage and required reason and informed analysis. If the applicant is not credible, serious doubts might arise about his characterizations of his physical, mental and emotional state which in turn impacts the assessment of the extent of permanent disability.

In light, the board exceeded its powers and its decision was unreasonable, since a denial of due process occurred.

The court concluded by declaring that a number of the board's contentions on review were without merit, directing harsh criticism that the board for its view that the only issue reviewable were those of earnings, permanent disability level and apportionment, since other issues such as temporary disability in psychiatric industrial injury had been decided at earlier hearings and had long ago become final. On the contrary, said the court, the only final decision was the one following the last hearing.

As to the board's contention that, at the April 2009 hearing defendant had failed to make an offer of proof Re: it's: cross-examination, the court responded that such an offer was not necessary. Because defendant had been quite clear about its purpose each time, the board is simply wrong.

Furthermore the court went on to state that the board's views do not square with the fact that it warned applicant twice that he must subject himself to cross-examination, but inexplicably abandoned that view when it issues its final decision.

The board exceeded its powers and adopting the decision flawed by denial of due process and the decision must be set aside.

4. Lien Activation Fee

Angelotti Chiropractic, Inc. v. Baker (9th Circuit) 80 C.C.C. 672

In 2012 S.B. 863 was enacted. 863 imposed a \$100 activation fee on lien claimants for each lien filed prior to 1/1/2013. Plaintiff sued claiming that SB 863 violated the takings clause, the due process clause, and the Equal Protection Clause. Plaintiffs filed a motion for a preliminary injunction. After hearing and argument the federal district court ruled to dismiss plaintiff's due process and taking claims without leave to amend. The court denied defendant's motion to dismiss the equal protection claim and the court issue a preliminary injunction in plaintiffs favor as to the equal protection claim. Defendants appeal the district court's issuance of the preliminary injunction and the denial of the motion to dismiss the equal protection claim. The plaintiffs cross-appealed as to the dismissal of their takings and due process claims.

The appellate court addressed each claim separately. They first analyzed the takings claim. Citing *Graczyk v. WCAB* 184 Cal. App. 3d 997 which found that the right to workers' compensation is wholly statutory and such right are not vested until they are reduced to a final judgment. Since an injured workers; right to benefits does not vest until final judgment the same is true for the liens at issue which are derivative of the underlying claim. They stated that plaintiffs were not under any compulsion to provide services but did so freely with the expectation that they might be compensated. Provided payment is made SB 863 does not affect plaintiff's ability to obtain payment on outstanding liens. They did not find the economic impact of SB 863 sufficient to constitute a taking.

The court then went on to analyze the due process violation claim. They explained that the activation fee is akin to a court filing fee which the courts have consistently upheld. The court concludes that the lien activation fee does not burden any substantive due process right to court access. They reject the plaintiff's claim that the retroactive nature of the lien activation fee violates the due process clause. They state that there is no dispute that the legislature intended for the lien activation fee to operate retroactively. They further conclude that the retroactivity of the fee does not violate due process since it is justified by a rational legislative purpose.

The court then turned to defendant's' claim that the district court abused its discretion in issuing a preliminary injunction on the ground that the lien activation fee violates the equal protection clause. Plaintiffs contend there is a due process violation since L.C. 4903.06(b) exempts certain entitles other than plaintiff from having to pay. The court rejected plaintiffs' argument that strict scrutiny applies since the fee does not implicate a fundamental right. They find that equal protection challenges to economic legislation are evaluated under a rational basis review. Under a rational basis review as long as there is any reasonable conceivable state of facts that could provide a rational basis for the classification it must be upheld. Here, the policy goal of helping to clear the lien backlog was sufficient to find that the statute is rationally related to a legitimate

policy goal. Therefore, the court found on this record “the relationship of the classification to the legislature’s goal is not so attenuated as to render the distinction arbitrary or irrational”.

The court found that the prior reasoning denies the legislature the leeway to tackle the lien backlog piecemeal, focusing first on the source of liens that it could have rationally viewed as the biggest contributor to the backlog. They conclude that the district court abused its discretion in finding that a “serious question” exists as to the merits of the plaintiffs’ equal protection claim. Therefore the court found, in the absence of a serious question going to the merits of the claim the preliminary injunction must be vacated. The court further reversed the district court’s denial of the motion to dismiss the equal protection claim.

In conclusion the court vacated the preliminary injunction and reversed the denial of the motion to dismiss the equal protection claim. The court affirmed the district court’s dismissal of the plaintiffs’ claims under the takings clause and the due process clause.

5. DFEC

Contra Costa County v. WCAB (Dahl) (Court of Appeal Published) 80 C.C.C. 1119

The Worker’s Compensation Judge issued an award for 79% permanent disability based on applicant showing that the diminished future earning capacity was higher than the 59% indicated by the rating pursuant to the PDRS. The WCJ applied the Leboeuf exception to the Ogilvie decision (76 CCC 624). The Judge concluded that the Ogilvie method could be applied to a partial permanent disability case and the vocational expert’s testimony rebutted the PDRS. The Judge stated that no nonindustrial factors had been used in preparing the DFEC calculations; applicant’s earning capacity had been calculated based on that of similarly situated employees.

The WCAB affirmed the WCJ. The WCAB observed that a Leboeuf analysis could be used even when the workers DFEC is not total. The board concluded that the rating schedule could be rebutted where the injury impairs the possibility for rehabilitation and for that reason the DFEC is greater than that reflected in the schedule rating. The board rejected the notion that a complete lack of amenability to vocational rehabilitation is necessary before the LeBouef exception can be applied. The panel also concluded it was proper not to consider individualized factors in determining the DFEC. The Court of Appeal granted review.

The Court of Appeal indicated Ogilvie held that the rating schedule is prima facie evidence of permanent disability percentages for covered injuries. Although the statutory schedule was presumed correct the court in Ogilvie ruled that it could be rebutted under three long-established legal principles: (1) where a factual error has been made in applying a formula or preparing the schedule; (2) where the worker shows that the injury impairs his or her rehabilitation, causing a DFEC greater than that reflected in the scheduled rating; and (3) a rare situation where the data

used to prepare the DFEC failed to fully capture the severity of all the medical complications of the injury.

The Ogilvie Court derived the second method from the Supreme Court opinion in Lebouef, which determined that an injured worker unable to be retrained for any suitable gainful occupation may be adversely affected and unable to compete in the open labor market, a factor that should be considered in rating permanent disability. The Ogilvie Court limited that approach to instances where the DFEC factors are directly attributable to the industrial injury and not to nonindustrial limitations such as literacy or lack of education.

The court ruled in the present case applicant's efforts to rebut her rating does not resemble any of the three methods described in Ogilvie. Applicant did not show her injury kept her from engaging in vocational rehabilitation. Her own expert concluded she was a good vocational rehabilitation candidate. The core of her rebuttal is that her experts analysis of her earning capacity-based on a comparison of earning loss of a group deems similarly situated to the applicant with a group identified in the rating schedule with applicant's characteristic-justified a higher rating. This is at odds with Ogilvie, which rejected a similar attempt to substitute an alternative methodology for the statutorily prescribed rating system.

The Ogilvie court indicated that rebuttal could only rarely take place. In a LeBoeuf analysis the initial step is to learn whether the industrial injury precludes the worker from using vocational rehabilitation to return to the labor force, and individualized process focusing on the limitations emanating from the workers particular state, not the earning potential of similarly situated persons that might have different limitations.

Neither Ogilvie nor the cases at issue suggests that such a departure from the statutory system is allowable whenever a worker cannot resume his or her pre-injury earning capacity. In this case the record shows no basis to conclude that the applicant rebutted her scheduled DFEC by proving she was not amenable to vocational rehabilitation.

The WCJ had ruled that the applicant had rebutted the scheduled rating, but what was not considered was whether her injury impaired or vocational rehabilitation prospects, not whether such impairment caused her a greater loss of earning capacity, as Ogilvie requires.

On reconsideration, the board disagreed that ability to rehabilitate was available only in cases of total permanent disability, accepting the argument that a LeBoeuf type of analysis can be used when vocational rehabilitation is unavailing. The board concluded that the complete lack of amenability to rehabilitation is not necessary for a LeBoeuf analysis-accepting applicant's methodology of looking at the effect such an injury would have upon the DFEC of similarly situated workers.

The court expressed skepticism of the board's conclusion that a worker may invoke the second Ogilvie Rebuttal method where the inability to rehabilitate causes less than 100% PD, but observed that it need not decide the validity of that issue, since the partial impairment rule was not challenged by seeking review. In any event even if the applicant's ability to undergo vocational rehabilitation need only be impaired and not eliminated in order to rebut the schedule, applicant failed to make the requisite showing, since all parties agreed that she was a good vocational rehab candidate, and the evidence showed she could raise her earning capacity through retraining.

The court also rejected applicant's argument that she successfully rebutted the scheduled rating because the state ceased providing vocational rehab programs as of January 2003, observing that Labor Code 4658.5 provides for retraining tuition cost vouchers. The applicant in Ogilvie was presumably eligible for such benefits, since the provision was last amended in 2003.

Moreover, Ogilvie holds the claimants must show non-amenability for vocational rehabilitation due to the effects of the injury and not due to extraneous factors; to hold otherwise would mean every worker could now rebut his or her schedule rating with a LeBoeuf analysis, turning a limited exception into a general rule. The exception is not intended to be all-encompassing.

The board's decision was annulled and the matter was remanded for further proceedings.

6. Going and Coming Rule

Schultz v. WCAB (Court of Appeal Published) 80 C.C.C. 16

The WCJ ruled that a car accident, which occurred on the grounds of Edwards Air Force Base on applicant's way to work as a technical drafter for a military contractor, was not barred by the going and coming rule.

The WCAB reversed the WCJ and found the case barred by the going and coming rule.

The Court of Appeal stated pursuant to the going and coming rule an award of workers' compensation benefits is generally not available for injuries suffered by an employee during a local commute to a fixed place of business at fixed hours, because the injury does not occur during the ordinary course of employment.

However, the ordinary course of employment is deemed to commence when an employee enters the employer's premises (the premises line rule), and at that point, the going and coming rule does not bar workers' compensation liability.

The Court of Appeal held that the premises line rule applied to an employee injured in a single-car accident, and therefore the injury was compensable, because: (1) the employee was a civilian working on a secure U.S. Air Force base not generally open to the public; (2) the employee

entered the base in his personal vehicle after passing a guard gate using a security pass issued by his employer with the approval of the Air Force; (3) the employee had traveled one mile inside the base when the accident occurred; and (4) the undisputed evidence established that although the employee worked out of a fixed location, the employer had multiple locations on the Air Force base and the employee travelled sometimes in his own vehicle, as needed, throughout the base to perform work assigned by his employer.

7. Record Development

Radiator USA v. WCAB (Kang) (Court of Appeal, not published) 80 C.C.C. 79

The WCJ found industrial causation of applicant's psychiatric injury and sleep disorder and the WCAB denied reconsideration of defendant's appeal.

The Court of Appeal reversed the WCAB and remanded the matter for further proceedings consistent with the opinion.

The Court of Appeal stated that pursuant to Labor Code § 3208.3 a psychiatric injury is compensable if actual events of employment were predominant to all causes combined of the psychiatric injury. The phrase "predominant cause" has been found to be greater than a 50% share of the entire set of causal factors. Causation of the psychiatric injury requires competent medical evidence.

The issue presented to the court was whether there was substantial evidence to support the board's decision finding injury.

The court indicated the sole medical evidence of industrial causation came from psychologist Dr. Nogales.

The court indicated the Appeals Board addressed the examination conducted by Dr. Bluestone, rheumatologist. That report noted the applicant was severely fatigued and suffering from a significant depression. However the court went on to state that the physician was not qualified to render a psychiatric evaluation as to depression and in addition there was nothing in the report speaking about the cause of the condition.

Dr. Nogales found the applicant's psychiatric condition was the result of his orthopedic injuries. However Dr. Nogales was completely unaware of the fact that the orthopedist, Dr. Pechman, had apportioned 50% of the orthopedic injury to nonindustrial pre-existing bone disease.

The court then asked the question does this mean that 50% of the psychiatric injury is attributable to non-industrial causes. The court stated that while they acknowledge that these determinations cannot be made with mathematical precision, it is at least a major issue what portion of the psychiatric injury is attributable to nonindustrial causes. Although 50% is a

reasonable surmise, on this silent record it is equally plausible to suppose that, given that psychiatric evaluations are unavoidably case-specific, 60% of the psychiatric injury-or 40% thereof-is attributable to non-industrial causes. The court then stated what is needed here is an expert opinion that is based on a complete medical history, which necessarily includes the orthopedist finding that 50% of the orthopedic injury is attributable to nonindustrial causes.

Dr. Nogales expressly deferred the issue of apportionment to a time when she would have seen all the medical and employment records. Notwithstanding her refusal to comment on apportionment, and irrespective of the orthopedist allocating 50% of the orthopedic injury to non-industrial causes, the Appeals Board accepted the psychologist's conclusion that the percentage of total causation of the applicant's current mental disorder is estimated at a higher level than the legal threshold of industrial causation of 50%. This opinion, however, could hardly have been anything more than tentative and entirely conditional on the review of records that the physician very candidly knowledge she had not seen. Given its admitted limitations the report is not competent medical evidence on the cause of applicant's psychiatric injury and sleep disorder.

The court went on to state that given the lack of competent medical evidence on causation, the decision of the Appeals Board cannot stand. The question then became whether it was appropriate to return the case for further development of the record on the issue of the cause of the psychiatric injury and sleep disorder.

The Court of Appeal stated that Labor Code § 5906 specifically empowers the Appeals Board to take additional evidence upon the filing or granting of a petition for reconsideration. Independently of a petition for reconsideration, Labor Code § 5701 empowers the Appeals Board to cause testimony be taken and, among other things, to direct the performance of medical evaluations. The Appeals Board may not leave undeveloped matters which it acquired specialized knowledge should identify as requiring further evidence. Under these circumstances the Appeals Board has the responsibility of seeing to it that such evidence was reasonably complete, whether by use of its own medical experts or otherwise. The Appeals Board has an affirmative duty to develop an adequate record. The appeals court as an example stated that where medical evidence was evenly balanced on the issue of industrial causation, the Supreme Court held that the Appeals Board was not free to simply rule the employer failed to sustain his burden of proof but was required to take additional evidence in order to resolve the doubts raised by the existing medical reports. (Lundberg v. WCAB 33 CCC 656). It has been held that the full development of the record to enable a complete adjudication on the merits is an employee's due process rights. (Tyler, McClune, and M/A, Com-Phi)

The court then concluded that the medical reporting this case had a serious flaw which the Appeals Board should have recognized and, at the responsibility to cure. The decision was annulled and the matter remanded for further proceedings consistent with the opinion.

8. QME Process

Batten v. WCAB (Court of Appeal Published) 80 C.C.C. 1256

Applicant sustained injury to her jaw, shoulders, knees, neck, and low back arising out of and occurring in the course of her employment as a registered nurse. She also claims she sustained a psychiatric injury as a result of the physical injuries. The parties selected an Agreed Medical Evaluator in psychiatry. The physician found the applicant's psychiatric injury was not predominantly caused by her employment.

The Worker's Compensation Judge authorized the applicant to obtain their own qualified expert in psychology at her own expense pursuant to section 4064 (d). That physician opined that 51% of applicant psychiatric condition was due to work-related injuries and therefore she sustained a psychiatric injury.

The matter proceeded to trial the WCJ found the medical report of the physician obtained pursuant to LC 4064 (d) the better reasoned and more persuasive. The WCJ found the applicant sustained a psychiatric injury. Defendant filed a petition for reconsideration arguing the report was not admissible.

The WCAB granted reconsideration and issued an opinion and decision concluding the report was not admissible and the WCJ should have relied on the report of the Agreed Medical evaluator. The board concluded that LC 4064 (d) provides that medical legal evaluations obtained outside the procedures of 4060, 4061, 4062, 4062.1 4062.2 are not admissible. Applicant filed a petition for writ of review.

The Court of Appeal indicated that 4064 (d) provides that if a medical evaluation is required to determine compensability at any time after the filing of a claim form, and the employee is represented by an attorney, a medical evaluation to determine compensability shall be obtained only by the procedure provided in LC 4062.2.

LC 4062.2 (a) provides that whenever a comprehensive medical legal evaluation is required to resolve any dispute and if the employee is represented by an attorney, the evaluation shall be obtained only as provided in this section.

The Court of Appeal indicated that the board concluded the procedures set forth in section 4062.2 are the exclusive method for obtaining medical evaluations for compensability because the mandatory language used in sections 4060 and 4062.2 does not allow for admission of medical legal evaluations obtained outside the scope of sections 4060 and 4062.2.

The applicant argued that section 4064 (d) permitted the admission of a privately obtained expert reports. LC 4064 provides that all comprehensive medical evaluations obtained by any party shall be admissible in any proceeding before the Appeals Board except as provided in section

4060, 4061, 4062, 4062.1 or 4062.2. Section 4060, 4062, 4062.1 and 4062 .2 specifically preclude the admission of an independently retained expert.

Had the legislature intended to permit the admission of additional comprehensive medical reports, obtained a party's own expense for the sole purpose of rebutting the opinion of the QME, it would have said so. The plain and unambiguous language of section 4061 (i) precludes such an interpretation.

The court went on to indicate the conclusion is supported by a significant panel decision (*Ward v. City of Desert Hot Springs* (71 CCC 1313)). In *Ward*, the board held that disputes regarding the compensability of alleged industrial injury must be resolved, pursuant to section 4060 (c), by the procedure provided in section 4062.2 and that an evaluation regarding compensability may not be obtained pursuant to section 4064.

The applicant argued that he could obtain such a report under Labor Code section 4605. That section provides nothing contained in this chapter shall limit the right of an employee to provide, at his or her own expense, a consulting physician or attending physicians whom she desires. Any report prepared by consulting or attending physicians pursuant to this section shall not be the sole basis of an award of compensation. A qualified medical evaluator or authorized treating physician shall address any report procured pursuant to this section and shall indicate whether he or she agrees or disagrees with the findings or opinions stated in the report shall identify the bases for this opinion. That is exactly what had happened here.

The board concluded the term consulting physician in LC 4605 means a doctor who is consulted for the purposes of discussing proper medical treatment and not one who is consulted for determining medical-legal issues and rebuttal to a panel QME. The Court of Appeal agreed. Neither section 4605 or 4061 permits the admission of a report prepared by an expert who is retained solely for the purpose of rebutting the opinion of an agreed medical evaluator.

The decision was affirmed.

9. Presumption

Lozano (William) v. WCAB (Court of Appeal Published) 80 C.C.C. 407

The WCJ first held the cancer presumption of § 3212.1 should not apply to the facts of this case because the cancer manifested itself before the amendment to the Labor Code section and without presumption the employee failed to show the cancer was work-related. The WCJ declined to apply the statute retroactively and denied workers' compensation benefits to the widow and two children. Following a petition for reconsideration and after lengthy analysis, the WCJ revisited the issue and issued a new decision.

The WCJ held the cancer presumption of § 3212.1 should be applied retroactively based on the liberal construction mandate of § 3202 to interpret the statute in applicant's favor. The facts of this case established the cancer presumption section was not amended until the cancer of the applicant had manifested itself.

The WCAB reversed indicating the legislature had not intended to apply the section retroactively and denied the dependent benefits.

The Court of Appeal indicated the issue was whether the cancer presumption for firefighters serving a DOD installations enacted in 2009 could be applied to a death benefit claim filed November 3, 2009 and adjudicated in 2013.

The court began by noting that a new statute is presumed to operate prospectively absent an express declaration of retroactivity or a clear showing that the voters or the legislature intended otherwise. The court went on to state that this presumption does not, however, bar application of new procedural or evidentiary laws to post-enactment trials, even though they might evaluate conduct that occurred before enactment; such laws usually affect only future conduct of post-enactment trials. That is, procedural changes may govern facts that existed before their enactment; in that sense, their application is prospective since they relate to future procedures and it would be a misnomer to characterize them as having retroactive effect.

By contrast, the court continued, when a statute alters the legal effect of past conducts or events, it is deemed substantive. Substantive statutes are deemed impermissibly retroactive when they alter legal consequences of past events. Use of the statutory change that imposes new and different rights or liabilities for past conduct, or that substantially affects existing ones, is barred, absent specific legislative intent to the contrary.

The distinction between substantive and procedural changes depends on their functional effects, not on labels. The application of procedural changes is deemed prospective and is allowed in post-enactment adjudications.

In this case the court reasoned the extension of the cancer presumption to DOD firefighters did not alter the test for liability, but only reallocated the burden of providing evidence by placing it on the employer. Absent evidence that no work exposure to a carcinogen was linked to a disabling cancer, the workers entitled to a finding of cancer arose out of and in the course of employment. Thus, making the presumption available to firefighters serving on DOD installations regulates the procedures to be used in determining the rights of such persons as decedent and their families. In allocating the burden of producing evidence it is a matter of procedure. The presumption does not change the legal effect of the past events and its application to post-enactment litigation is both prospective and proper.

The WCAB erred in holding that allowing the use of the cancer presumption extension was retroactive application of law.

The Court of Appeal found it was unclear whether the board had refused to apply the presumption because the firefighter died before the operative date of the presumption, or because his cancer manifested itself before that date. The WCAB decision was annulled and the matter remanded.

10. Medical Treatment

Stevens v. WCAB (Court of Appeal Published) 80 C.C.C. 1262

The applicant challenged the constitutionality of the IMR process. The Court of Appeal concluded that the applicant's stated constitutional challenge failed because the legislature has plenary powers over the workers' compensation system under the Constitution of the state of California.

They further concluded that her federal due process challenge fails because California's scheme for evaluating a worker's treatment request is fundamentally fair and affords workers sufficient opportunities to present evidence to be heard.

They further concluded that the WCAB misunderstood its statutory authority in one respect when it reviewed the applicant's appeal. The board concluded it was unable to review the portion of the IMR determination that found, "medical treatment does not include personal care given by home healthcare aides when this is the only needed care". The WCAB is empowered to review an IMR decision to consider whether care was denied without authority because the care is authorized under the MTUS. They therefore remanded the matter to the board to consider whether the applicant's request for home health aide was denied without authority.

The applicant's treating physician submitted the request for four medications to relieve applicant's pain and also sought approval for the services of a home health aide for eight hours a day for five days a week. The aide was to help the applicant with bathing and dressing, moving about her home, preparing meals, and picking up medications from the pharmacy.

Applicant's request was submitted to UR. The UR physician denied the request and provided an extensive nine page rationale for his decision. The UR decision was timely conducted and properly communicated. The applicant requested internal review, at least regarding denial of the request for the four medications. The review was conducted by another UR physician who concluded that the request for the medications should be denied. The applicant was notified of the internal review decision.

The applicant then filed for Independent Medical Review. The IMR determination upheld the UR denial of the requested medical treatment. The determination did not identify the IMR

physician reviewer but reported the reviewer was board-certified in pain management and a subspecialty in disability evaluation and license to practice medicine in California. The IMR determination became the determination of the Dir. of the Division of Workers' Compensation as a matter of law.

The applicant appealed the IMR determination pursuant to Labor Code section 4610.6 (h). She claimed among other things that LC 4610.6 violated her due process rights. The appeal was heard by a Worker's Compensation Judge, who concluded the appeal was not cognizable because it was not brought on grounds permitted by LC 4610.6 (h). The judge concluded the board and no jurisdiction to consider the constitutionality of LC 4610.6. Applicant filed a Petition for Reconsideration.

The WCAB denied reconsideration accepting the recommendation of the WCJ. In doing so, the WCAB agreed that the judge had no authority to determine the constitutionality of the IMR statutes as sought by the applicant. The WCAB ruled it does not matter whether reasons given for an IMR determination support the determination unless the appealing party proves one or more of five grounds for appeal listed in LC 4610 (h) by clear and convincing evidence and the applicant did not do so in this case.

Applicant filed a writ of review.

The Court of Appeal concluded that the plenary powers over the workers' compensation system conferred on the legislature by section 4 are not limited by the State Constitution's separation of powers or due process clauses. The IMR process does not violate section 4 of the state Constitution.

In establishing the IMR process, the legislature found that the former system of resolving disputes over the medical necessity of requested treatment impeded justice because it was costly and time-consuming, and prolonged disputes and cause delays in medical treatment for injured workers. It found that independent and unbiased medical expertise of specialists is necessary for timely and medically sound determination of disputes over appropriate medical treatment.

Similarly, it found that having medical professionals ultimately determine the necessity of requested treatment furthers the social policy of the state in reference to using the evidence-based medicine to provide injured workers with the highest quality of medical care and that the provisions of the act establishing independent medical reviewer are necessary to implement that policy.

Finally, it is found that the establishment of independent medical review and provisions for limited appeal of decisions resulting from independent medical review are a necessary exercise of the legislature's plenary power to provide for the settlement of any disputes arising under the workers' compensation laws of this state and to control the manner of review was such decisions.

In sum, the legislature found that, far from conflicting with section 4's mandate to provide substantial justice, the IMR process furthers it. The court indicated it is not their place under the Constitution to second-guess the wisdom of the legislature making these determinations. The Court of Appeal concluded that there is no basis to conclude that in establishing the IMR process the legislature acted outside of its plenary powers to enact appropriate legislation governing workers compensation.

The Court of Appeal further concluded that the IMR process did not violate federal due process.

The court also rejected the applicant's argument that the IMR process violated due process because the physician reviewer is anonymous and not subject to cross-examination. The reviewers are not workers adversaries: they are statutorily authorized decision-makers. The court found no authority for the proposition that a party has a right to cross-examine such decision-makers.

The applicant also argued that, regardless of the opportunities to be heard, LC 4610.6 violates due process because it limits and precludes any meaningful appeal of an IMR determination and provides no means to address conflicts about what constitutes medical treatment. The court went on to indicate that IMR determinations are subject to meaningful further review even though the board is unable to change medical-necessity determination.

The board's authority to review and IMR determination includes the authority to determine whether it was adopted without authority or based on a plainly erroneous fact that is not a matter of expert opinion. These grounds are considerable and include reviews of both factual and legal questions.

If, for example, an IMR determination were to deny certain medical treatment because the treatment was not suitable for a person weighing less than 140 pounds, but the information submitted for review showed the applicant weighed 180 pounds, the board could set aside determination as based on a plainly erroneous fact.

Similarly, the denial of a particular treatment request on the basis that the treatment is not permitted by the MTUS would be reviewable on the grounds that the treatment actually is permitted by the MTUS. And IMR determination denying treatment on this basis would have been adopted without authority and thus would be reviewable.

In this case the board failed to appreciate the latter point. In its final order, it ruled that it was powerless to review the IMR determination categorically denying the applicant service of home health aide, even though it concluded the applicant's condition requires care other than homemaker service and considered puzzling the determination statement that the medical treatment does not include personal care given by home health aides like bathing, dressing and using bathroom when this is the only care needed. But whether home healthcare services or

authorize when bathing, dressing, using the bathroom is the only care needed is a question to resolve by reviewing and interpreting the MTUS , and if were to find there were no other reason supporting the denial, it would have the power to conclude that the determination was adopted without authority.

The court disagreed with the applicant that the IMR provides no means to address conflicts about what constitutes medical treatment and no meaningful appeal to challenge an IMR decision based on erroneous interpretation of the law. They rejected the applicant's argument that the IMR process violates due process because there are no meaningful enforcement procedures of the statutory time limits for IMR decisions.

In its final decision, the board noted that the applicants IMR determination took over seven months and found fault with the lack of statutory mechanism to enforce LC 4610.6, the requirement that IMR determinations be made within 30 days. The appellate court was unconvinced that the lack of a mechanism to enforce time limits renders them IMR process unconstitutional. In the absence of penalty, consequences, or contrary intent, time limit is typically considered to be directory, in violation does not require the invalidation of the action to which the time applies.

Furthermore, without deciding whether a writ of mandate may have been available to enforce the time limit, the court noted the applicant did not attempt to seek one or otherwise to insist on timely compliance.

The decision of the board after reconsideration was affirmed, except they remanded the matter to the board for determination whether the director acted in excess of authority in deciding that personal care given by home health aides was not medically necessary for the applicant.

11. Cost of Compensation

Lewings v. Chipotle Mexican Grill, Inc. (Court of Appeal Unpublished) 80 C.C.C. 1169

This matter is an appeal from a dismissal of a class action following a successful demurrer by the defendant to Plaintiff's third amended complaint. The plaintiff filed suit on behalf of all hourly employees who worked for Chipotle for the 4 years prior to 10/22/2013. A company named Shoes for Crews markets a nonslip shoes to employers by offering to reimburse them for thousands of dollars in W.C. related medical expenses if an employee is injured in a slip and fall while on the job. Chipotle implemented a Shoes for Crews program in which employees were permitted to buy these shoes directly through payroll deductions. Based on its employees wearing these shoes; Chipotle obtained a reduction in its W.C. premiums. Chipotle deducted money from plaintiff's check for these shoes. Shoes for Crews paid \$25,000 to offset the costs of medical bills arising from injuries sustained by employees. Plaintiff brought suit alleging that

defendant violated L.C. Sections 3751 and 3752 by requiring employees to bear the cost of workers' compensation expenses.

L.C. Section 3751 states "No employer shall exact or receive from any employee any contribution, or make or take any deduction from the earnings of any employee, either directly or indirectly, to cover the whole or any part of the cost of compensation under this division. Violation of this subdivision is a misdemeanor." The court looked to the definition of compensation in the statute. Compensation in 3751, the court determined, is any compensation under Div. 4 of the Labor Code including L.C. Section 4600 which requires an employer to provide an injured employee with medical treatment to cure or relieve from the effects of the industrial injury. According to the plaintiff when the employees purchased the shoes they indirectly contributed to the cost of compensation because their purchases results in the defendant receiving warranties from Shoes for Crews designed to offset the medical expenses. Based on the plain meaning of the statute the court agreed. The court found that 3751 requires the employer to bear the entire cost of securing compensation thus when employees purchased the shoes they secured at least part of the cost of compensation. They found no difference between deducting wages to pay for workers' compensation insurance versus receiving the warranty from Shoes for Crews. They further found that an injury is not required to give rise to a violation of 3751 as defendant alleged. They determined that defendant knowingly accepted warranties funded by its employees and therefore violated the statute. However, even though the court found the violation they further found that the legislature did not intend to allow employees wronged by it to seek damages. They concluded that 3751 does not give rise to a private right of action.

The judgment of dismissal for violation of section 3751 was affirmed.

12. Coverage

American Home Assurance v. 99 Cents only Stores (Court of Appeal Unpublished) 80 C.C.C. 503

American Home issued Workers' compensation policies to Optima Staffing for 2008 and 2009 based in part on Optima's representation that it was a temporary staffing agency and not a professional employer organization, which provided administrative services and procured workers' compensation insurance on behalf of employers for employees that Optima did not directly train, hire or supervise. After defending and indemnifying 175 W.C. claims American Home found that Optima was acting as a PEO for several temporary staffing agencies and their special employer clients. The Insurers rescinded the policy and filed an action to confirm the rescission and for restitution from the temporary staffing agencies and the special employers although they were not seeking to recover from the injured workers directly or to terminate any

agreed upon benefits. The trial court entered judgment for the staffing agencies and the special employers of which the Insurers appealed.

In January of 2011 the Insurers filed a first amended complaint and also named the director of industrial relations since workers injured while employed by uninsured employers may be paid by the UEBTF due to the lack of insurance. In October of 2011 2 staffing agencies demurred since they were not parties to the agreement and claimed the contract could not be rescinded as to them since their rights had intervened and rescission would harm them. They argued that they had reasonably relied upon the policies obtained by Optima. The trial court sustained the demurrers explaining that the insurers were not entitled to rescission against one who is not a party as they would suffer prejudice.

On appeal the appellate court stated that an insurer may rescind a policy when the insured has misrepresented or concealed material information. After rescission the insurer may bring an action for declaratory relief to enforce it. When a policy is rescinded it is void ab initio. It renders the policy totally unenforceable. The court found that defendants could rescind the policy even though they were not seeking reimbursement from injured workers. Defendant also argued that the policy could not be rescinded because injured employees have already accepted benefits under the policy. The court found that the injured workers were not intended beneficiaries of the policy and since the injured workers would ultimately be paid by either UEBTF or the employer's policies they will not be harmed by the rescission.

Defendants argued that they legitimately purchased workers' compensation insurance without any notice of Optima's fraud and they will be harmed if recession is allowed since workers could now pursue tort claims against them. The court determined that it could not be found at this stage if the right of the defendants has been sufficiently prejudiced to prevent rescission.

The court upheld the determination on the claims for quantum meruit and found the insurers failed to state a claim on that cause of action. The judgments were reversed as to the orders dismissing the causes of action for declaratory relief and unjust enrichment.

13. Evidence

Velasquez v. Centrome (Court of Appeal Published) 80 C.C.C. 134

Plaintiff was employed with Gold Coast, a company that made food flavorings. During an accident applicant was exposed to fumes in September of 2005. In 2006 applicant was diagnosed with progressively fatal lung disease. The matter proceeded to trial against several manufacturers and distributors of the chemical compounds.

Prior to trial several motions in limine were brought. One of which was to exclude Velasquez's undocumented worker status. The court was clearly very concerned about the prejudicial value

of that information. Plaintiff argued that it was irrelevant since there was no loss of earnings claim presented and not relevant. A doctor testified that the issue would be relevant as to if he would receive a lung transplant. Thereafter the court deemed the information admissible. After the jury was empaneled there were a few jurors that asked to speak with the judge and advised that the alien status would affect their decision. Those jurors were dismissed. At multiple points throughout the trial the plaintiff's attorney requested a mistrial due to that information being presented.

After trial began additional experts testified the immigration status would not be taken into account to determine his viability for a lung transplant. The matter went to a jury verdict and the jury found, among other things, that the defendant had been negligent but the negligence was not a substantial factor in causing the harm to Velasquez. On appeal the appellate court made the following findings: No evidence is admissible except for relevant evidence. They agreed that when an undocumented immigrant files a personal injury action but does not claim damages for lost earnings evidence of his or her immigration status is irrelevant. It is not relevant to damages. Further immigration status alone has no tendency in reason to prove or disprove any fact material to the issue of a party's credibility. The jurors should not have been informed of the undocumented status of the plaintiff. The court notes that in California and multiple other jurisdictions the courts have recognized the strong danger of prejudice attendant with the disclosure of a party's status as an undocumented immigrant. The appellate court found that the trial court abused its discretion in determining the evidence was admissible under Evidence Code 352 and should not have allowed for Velasquez's immigration status to be presented to the jurors. The judgment was reversed and the case returned to the trial court.

14. Permanent Disability

Hallmark Marketing Corporation v.WCAB (Gannon)(Court of Appeal, not published) 80 C.C.C. 1132:

This case is a non-published opinion addressing the long-standing consideration of restrictions of work to a sheltered workshop or at home automatically entitles the injured worker to hundred percent PD. Instead the Court of Appeal indicated that in these situations the burden shifts to the employer to offer evidence that some work is available. The reasoning behind the court's decision is that because of advances in technology many jobs can now be done from home. Requests are being made because of the importance of this case that the court reconsiders its decision that this is a non-published decision.

Applicant suffered a severe industrial injury on December 13, 2000 to her low back, neck and bilateral carpal tunnels. The applicant underwent low back fusions in 2004 and 2007, both of which left her with complications including bladder, bowel and sexual dysfunction.

The parties chose the Agreed Medical Evaluator. The Agreed Medical Evaluator evaluated the applicant many times over 10 years.

The Agreed Medical Evaluator concluded that although the applicant might be able to do some part-time work outside her home, applicant was essentially 100% disabled from competing in the open labor market. A vocational expert did not share that view, but failed to consider applicant's bladder and bowel issues which were detailed by another Agreed Medical Evaluator.

The matter proceeded to trial and following trial the WCJ issued rating instructions. At the cross-examination of the rating specialists the specialist testified that the situation was analogous to that of a sheltered workshop, necessarily rated at 100% permanent disability.

The WCJ disagreed with the raters view that a sheltered workshop necessarily equates to 100% permanent disability, noting that sheltered employment carries that rating only if having to work from home is required by limitations that also make the worker uncompetitive in the open labor market. The judge went on to state that the vocational expert did not consider applicant's variable ability to function in at-home occupations for which she was otherwise qualified; absent such evidence, she was deemed permanently totally disabled, and award was made of 100%.

The WCAB agreed with the WCJ that the applicant was 100% permanently disabled. The panel did not adopt the judge's rejection of the vocational experts view that applicant could compete in the open labor market with at-home employment. The panel deemed a limitation to working from home analogous to working in a sheltered workshop, which rates 100% permanent disability, making applicant's ability to compete for jobs within the sheltered home environment irrelevant to the issue of the level of permanent disability.

Defendant filed a petition for review.

The Court of Appeal disagreed with the rater's conclusion that having to work at home due to a work restriction necessarily creates 100% permanent disability. The WCJ correctly stated that a worker is permanently totally disabled and having to work at home is necessitated by limitations that also render the worker unable to compete in the open labor market. Age and the digital revolution, with personal commuting and Internet, have substantially increase the possibilities of working at home, rendering obsolete the rater's view that having to work at home necessarily equates to 100% permanent disability. The Court of Appeal went on to state however, not everyone can support themselves by working at home. The WCJ's formulation of total permanent disability in such a context succinctly sets forth these modern realities in a practical standard, consistent with case law.

The court went on to discuss the odd lot rule of temporary disability. Under this rule, the temporarily disabled worker proves disability, just as he or she must prove industrial causation of the injury, and the burden then shifts to the employer to show that work is available that the

employee can perform. If no such work exists, the employer must pay temporary disability. The worker's labor has become an odd lot in the labor market, and the employer must prove that such special employment can be obtained.

The court recognized the difference between temporary disability and permanent disability but nevertheless applied the odd lot rule in allocating the burden of proof in the context of permanent total disability cases where there is a limitation to at work home only since such employees are in an even hotter lot in the labor market than injured workers in the context of temporary disability, the situation for which the rule was developed.

Consequently, once the injured worker has proven industrial causation and the ability to work only from home on work not generally available, the burden shifts to the employer to establish the worker's ability to compete in the open labor market, proving that such work is available.

In the present case the employer failed to meet that burden; thus the evidence was sufficient for the WCJ to find the applicant 100% permanently disabled.

The court annulled the WCAB's decision and remanded the case for the board to reconsider the matter in light of the court's opinion.

EN BANC AND SIGNIFICANT PANEL DECISIONS

15. Service

Joann Matute v. L.A.U.S.D. (en banc) 80 C.C.C. 1036

Applicant sustained a CT during the period September 1985 through 2/23/2006. The case was settled by way of stipulations with request for award at 37% with future medical. On 7/7/2014 the treating doctor issued a prescription for home health services. On 8/18/2014 an RFA was submitted. On 8/23/2014 defendant served applicant with a letter finding that the services were not medically necessary. On 9/4/2014 applicant filed a request for IMR. On 11/6/2014 a Final Determination Letter upholding the UR denial was issued. On 12/10/2014 applicant filed an appeal of the IMR determination. On 2/19/2015 the IMR appeal was heard by the WCJ. On 2/20/2015 the WCJ issued an F&O dismissing the IMR appeal as untimely. The WCJ concluded that the 30 day time period in which to file an IMR appeal pursuant to L.C. 4610.6 is triggered by the mailing of the IMR determination; that there is no mention of "service" in the code and that "mailing" is an act other than service. Applicant filed a petition for reconsideration. The WCAB issued an en banc decision.

The procedures relating to IMR review of UR determinations are governed by section 4610.6 and Rule 10957.1. Under 4610.6 an IMR appeal must be filed within 30 days of the date of mailing of the determination. 10957.1 states that the petition "shall be filed with the WCAB no later than 30 days after service by mail of the IMR determination" The issue is whether the

“mailing” of the written IMR determination is equivalent to and means service by mail, or if “mailing” is an act or occurrence other than service. The board cited *Messele v. Pitco Foods* 76 C.C.C. 956 whereby they allowed an additional 5 days for mailing during the AME selection process. They also cite *Razo v. Las Posas* which also allowed an additional 5 days for mailing after service of the QME panel assignment by the AD, even though it was not specifically stated in the statute.

The WCAB concluded that the term “mailed” in 4610.6(h), which is the trigger for the 30 day appeal period, is equivalent to and means “service by mail”. This finding was consistent with case law. They held that the 30 days period to file a timely appeal from an IMR determination under Section 4610.6(h) is extended five days pursuant to the provisions of Section 5316 and C.C.P. Section 1013(a). They concluded that applicant’s IMR appeal was therefore timely as it was filed on the 34th day. The F&O was rescinded and the matter returned to the trial level to consider the merits of the appeal.

16. Liens

Rogelio Cornejo v. Younique Café, Inc. (en banc) 2015 Cal. Wrk. Comp. LEXIS 160

The WCJ disallowed the lien claim of Western Imaging Services based on the finding the Business and Professions Code Section 22451 did not exempt the lien claimant from registration and bonding pursuant to B&P Code Sections 22450 and 22455. Further the WCJ found that lien claimant did not show that it was an independent contractor of a member of the state bar pursuant to B&P Section 22451(b) and therefore lien claimant was required to be registered and bonded in order to recover payment. Lien claimant filed for reconsideration arguing that the judge erred in disallowing the lien claim because it made a prima facie showing that it is an independent contractor of a member of the state bar as described in B&P Section 22451(b) and therefore lien claimant did not need to be registered and bonded.

The WCAB issued an en banc decision holding that the B&P Code did not apply to a lien claimant seeking to recover copy service fees that are medical legal expenses under L.C. Section 4620(a) when the lien claimant is an agent or an independent contractor of a member of the state bar at the time the documents are copied. Further, when a lien claimant makes an un rebutted prima facie showing that it is an agent and/or an independent contractor of a member of the state bar at the time of the copying of the documents proof of compliance with the registration and bonding provisions of the B&P Code section 22450 and 22455 is not required. The WCJ’s decision was rescinded. Liens

DENIALS OF WRITS OF REVIEW

17 . Medical Evidence

United States Fire Insurance Company v. WCAB (Montejo) (W/D) 80 C.C.C. 55

Applicant suffered an industrial injury to multiple body parts. Over the course of the next five years, applicant underwent multiple surgical procedures on his cervical spine and shoulders.

Defendant requested a report from internist Arnold Roth M.D. pursuant to Labor Code § 4064 (d), which allows an employer to obtain medical evaluation or consultation at its own expense, to address the appropriateness of the medical treatment applicant had received and should receive in the future, and to render an opinion regarding applicant's psychiatric state. Defendant provided the physician with medical records, applicant's deposition testimony, and surveillance videotape of the applicant. However the physician did not examine the applicant.

Arnold Roth M.D. issued a report in which he found that the treatment provided to applicant had been appropriate but that applicant had malingering tendencies and the applicant's level of disability was not reflected in the daily activities observed on the surveillance video provided. The physician also questioned the applicant's chronic pain and his ability to self- manage his pain. The physician recommended a neuropsychiatric consultation and using a non-surgical specialist as the primary treating physician.

Defendant sought to serve the report of Dr. Roth on the PQME, AME and applicant's primary treating physician. Applicant's attorney objected, fearing that, if the report was sent to the physicians in the case, the report would necessarily become part of the medical record.

The matter was submitted to the WCJ who issued a finding that defendant was not entitled to serve the report on any physician in applicant's case because the report was inadequate. The WCJ reasoned that the prejudicial potential of the report outweighed its probative value and it should not become part of the medical record. The WCJ pointed out that the physician never examined the applicant, that, as an internist, he was not qualified to address applicant's potential psychiatric problems, and that his qualifications to render opinions about appropriateness of spinal surgeries was not established. Additionally the WCJ noted the report lacked neutrality that his conclusions were unfounded and speculative, and the report contained multiple levels of hearsay.

Defendant filed a petition for removal.

The WCJ in his report indicated that the report lacked evidentiary value and was inadmissible. The WCJ concluded the report was deficient because the physician did not examine the applicant, made broad unsupported generalizations, based his opinions on unreliable hearsay,

and, as an internist, was not qualified to render an opinion as to applicant's psychiatric state or about applicant's spinal surgeries.

The WCJ further argued that the report did not contain a record review and did not qualify as a comprehensive medical evaluation pursuant to Labor Code § 4064 (d), which provides all comprehensive medical evaluations obtained by any party shall be admissible in any proceeding before the Appeals Board, except as provided in sections 4060, 4061, 4062, 4062.1 or 4062.2.

The WCJ further stated that even if defendant had the right under labor Code § 4064 (d) to obtain a report defendant did not automatically have the right to use that reported evidence.

The WCAB denied removal adopting the report of the WCJ.

A writ of review was filed and denied.

The Court of Appeal indicated that they could not say the WCAB acted unreasonably or in excess of its powers or that the decision was not supported by substantial evidence or procured by fraud.

The court went on to state that the employer may obtain a medical evaluation or consultation at its own expense pursuant to Labor Code § 4064 (d). Privately retained doctors reports are not barred from admission in disability hearings (Valdez). However, the WCAB may only rely on medical reports that constitute substantial evidence (Place). A medical report or opinion based on an inadequate medical history or examination, based on surmise speculation or conjecture does not constitute substantial evidence.

The court went on to indicate that the physician did not examine the applicant and he offered his opinions without adequate reference to specific facts in the medical record. Substantial evidence supports the WCJ's order barring petitioner from sending the reports to the treating physician, the QME's or AME.

18. IMR

Arredondo v. Tri-Modal Distribution Services (W/D) 80 C.C.C. 1050

Applicant contends that the IMR determination did not issue within the time specified in Labor Code § 4610.6 (d) and, for that reason, the WCAB has jurisdiction to determine the medical treatment dispute based upon evidence presented at the hearing.

The WCJ found that the WCAB lacked jurisdiction to review the denial of care issued by Utilization Review and upheld by Independent Medical review.

Applicant filed a petition for reconsideration.

WCAB affirmed the decision of the WCJ. The WCAB ruled that IMR is a governmental action and therefore the time frames set forth in Labor Code § 4610.6 (d) are directory and not mandatory. Since no ground for appeal of the IMR determination under section 4610.6 (h) were established the IMR determination in this case is final and binding on the applicant.

Labor Code § 4610.6 (d) provides that an IMR determination should issue within 30 days of receipt of the request for review and supporting documentation.

Administrative Director Rule 9792.10.5 (a) (1) provides that relevant documents in most instances are to be provided to the IMR organization within 15 days after the matter has been assigned for IMR. 15 days allowed by the AD to provide supporting documentation is in addition to the 30 day period prescribed for in section 4610.6 (d) because under that section the 30 day period does not begin to run until receipt of the supporting documentation. Thus, the time allowed from the date a request for regular IMR is reviewed to the date and IMR determination issues under the AD rules is 45 days because 15 days are allowed for submission and receipt of supporting documentation. (9792.10.4 (a) (5) and 9792.10.7 (g) (1).

The WCAB also did not agree with the WCJ statement and the report that an employee may appeal and IMR determination that has not yet issued pursuant to section 4610.6 (h) (1). This is because section 4610.6 (h) plainly provides for review of an IMR determination after it is issued. When the legislature enacted the UR process, it provided that medical treatment decisions be determined consistent with the Medical Treatment Utilization Schedule promulgated by the AD pursuant to section 5307.27 (Labor Code 4610 (c). The use of the MTUS as part of the UR process evidences the legislative intention to promulgate a uniform standard of reasonable medical treatment based on evidence base, peer-reviewed, nationally recognized standards of care.

The legislature enacted the IMR process in order to have medical professionals apply the MTUS and other treatment standards prescribed in section 4610.5 (c) (2) to determine medical treatment disputes not resolved by Utilization Review.

Labor Code 4610 (b) requires every employer to establish a UR process, and section 4610 (c) requires that UR policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of propose medical treatment services are consistent with the schedule for Medical Treatment Utilization adopted pursuant to section 5307.27.

Labor Code 4610.5 makes IMR applicable to any dispute over a utilization review decision, and requires that any such dispute shall be resolved only by IMR.

The legislature is directed that IMR determination shall be presumed to be correct and may be reviewed only by a verified appeal on one or more specified grounds. Untimeliness is not listed as a ground for appeal in section 4610.6 (h) and nothing in the IMR statutes authorizes a WCJ or

the appeals board to determine medical necessity. To the contrary, section 4610.6 (i) expressly provides that, in no event shall a Worker's Compensation administrative law judge, the Appeals Board, or any higher court make a determination of medical necessity contrary to the determination of the independent medical review organization.

The legislature further specified in section 4610.6 (i) that if an IMR decision is reversed as part of an appeal on the limited grounds specified in 4610.6 (h), the dispute is to be remanded to the AD for submission to another IMR.

All medical treatment disputes are to be determined by medical professionals using evidence-based, uniform treatment standards. The legislature charged the AD with the responsibility of conducting IMR. In this way, IMR is distinctly different than UR, which defendant is obligated to perform within the statutory and regularly time frame. (Dubon, 73 CCC 981).

As designed by the legislature, IMR is a governmental action that occurs under the auspices and control of the AD. The AD contracts with the IMR organization to conduct reviews and to assist the division in carrying out its responsibility. (Labor Code 139.5 (a) (2)).

The IMR organization and medical professionals who are retained to conduct reviews shall be deemed consultants who assist the AD in performing IMR. (Labor Code 139.5 (b) (1)). Services provided by the IMR organization are specifically declared by the legislature to be a state function as described in Government Code 19130 (b) (2) 139.5 (f).

The legislature specifically mandated or authorized the performance of the work by independent contractors. The AD reviews and approves employee requests for IMR. A determination by the IMR organization shall be deemed to be the determination of the AD and shall be binding on the parties.

In this case the WCAB stated there is no question that the legislature intended to guide the AD on when an IMR determination should issue when it enacted Labor Code 4610.6 (d). The legislature implemented no provision for invalidating an IMR determination that does not issue within the section 4610.6 (d) time frames. Construing untimeliness as grounds for appeal under section 4610.6 (h) would be inconsistent with the legislature's intention in enacting the IMR process because the remedy for a successful section 4610.6 (h) appeal is remand of the dispute to the AD for completion of another IMR. No valid purpose is served by having a second IMR performed when the only demonstrated concern with the first IMR determination is that it did not issue within the required time frames. Therefore the time frames in section 4610.6 (d) are properly construed to be directory and not mandatory. For that reason, an IMR determination is valid even if it does not issue within those time frames.

One Commissioner dissented and would have remanded the matter for the WCJ to determine if the IMR determination was late and if it was late the WCJ would determine whether the medical treatment is supported by substantial evidence.

19. Temporary Disability

Moore v. WCAB (W/D) 80 C.C.C. 299

The applicant claimed she suffered orthopedic and psychiatric injuries as a result of employment. Defendant stipulated to the orthopedic injuries but denied the psychiatric injury.

The matter proceeded to trial solely on the issue of temporary disability related to applicant's orthopedic injuries and statute of limitations. The WCJ issued a Findings and Award, finding that applicant's claim was not barred by the statute of limitations and awarding Temporary Total Disability benefits from July 8, 2011 through August 14, 2012.

The WCJ in awarding post-retirement temporary disability relied on the holding in the case of *González v. WCAB* (63 CCC 1477), in which the Court of Appeal held that while an employee is not entitled to post-retirement temporary disability if the employee indicates an intent to retire from all work, an employee forced to retire by reason of a work-related injury is entitled to temporary total disability after retirement. Defendant filed a petition for reconsideration.

The WCAB granted reconsideration and rescinded the WCJ's decision and held the applicant was not entitled to temporary total disability and benefits post-retirement.

In assessing applicant's entitlement to TD the WCAB considered whether applicant's admitted orthopedic injuries contributed to her decision to retire and resulted in a diminished earning capacity as contemplated in *Gonzales*.

The WCAB stated the decision to retire implicates the element of willingness to work in the earning-capacity calculus, and the primary factual component of the analysis must be whether the worker is retiring for all purposes, or only from that particular employment.

If the former, the worker cannot be said to be willing to work, and earnings capacity would be zero. If the latter then it would be necessary to determine and earning capacity from all evidence available.

A subsidiary question is whether the decision to retire is a function of the job-related injury. If the injury causes the worker to retire for all purposes or interferes with plans to continue working elsewhere, than the worker cannot be said to be unwilling to work and would have an earning capacity diminished by the injury. Thus, the worker may establish by a preponderance of evidence an intent to pursue was interrupted by the job-related injury.

In this case the board stated the applicant's retirement letter and her un-rebutted trial testimony indicates that she did not intend to retire when she did and did so reluctantly.

The WCAB pointed out, however, that, although applicant's retirement letter implicated her physical duties in her decision to retire, the record as a whole revealed the applicant retired when she did largely due to her perception of a hostile work environment, stress and mental abuse. Additionally, applicant's deposition testimony suggested that it was largely the emotional stress caused by her employment that forced her retirement.

The WCAB further found no substantial evidence supporting the conclusion that the admitted orthopedic injuries, standing alone, caused temporary total disability indemnity, since the orthopedic physician continued to believe the applicant was physically capable of working within the restrictions he impose and modified duties were offered to and undertaken by applicant and applicant voluntary left the modified duties because of stress.

The WCAB opined that applicant's trial testimony to the effect that she could no longer physically do the modified job was inconsistent with her statements at the time she retired, and was unsupported by the medical evidence. Applicant filed a petition for writ of which was dismissed. The writ was dismissed as there was no final order decision or award.

20. Substantial Evidence

Solano v. WCAB (W/D) 80 C.C.C. 394

Applicant sustained injury to her wrists, upper extremities and spine while employed as a stocker by Wal-Mart on 3/6/2006. She began treating with Dr. Scheinberg. Dr. Scheinberg diagnosed applicant with carpal tunnel syndrome, thoracic outlet syndrome and degenerative disc disease. Applicant was evaluated by Dr. Mays, QME. Dr. Mays rated applicant's disability at a 75 WPI. Dr. Scheinberg found a 12 percent WPI.

At trial the WCJ issued an F&A relying on the reporting of Dr. Mays to find that applicant sustained injuries causing 82% PD. Defendant filed for reconsideration alleging that the reporting of Dr. Mays was not substantial medical evidence.

The WCAB granted reconsideration and rescinded the F&A returning the matter to the trial level for a new PD rating based on the findings of Dr. Scheinberg. The WCAB explained that it found Dr. Scheinberg's opinion more convincing in light of the lack of objective findings and because Dr. Scheinberg was more familiar with the applicant's condition based on his years as her treating physician. Stating "on this record, we find the opinion of applicant's primary treating physician, Dr. Scheinberg constitutes the most persuasive description off applicant's permanent disability...." It should be noted that the WCAB did not find the reporting of Dr. Mays to not be

substantial evidence but found the reporting of Dr. Scheinberg to be more persuasive. Applicant filed a petition for reconsideration and a petition for writ of review. Both were denied.

21. Evidence

Creffitta, Inc. v. W.C.A.B. (Alvarez)(W/D) 80 C.C.C. 579

Applicant sustained injury on 12/22/06 to his left shoulder while working for an illegally uninsured employer. Following his injury applicant was terminated and eventually deported to Mexico. Applicant was unable to attend his trial. A hearing was held solely on the issue of whether applicant had the right to testify remotely via Skype. The WCJ issued an order allowing applicant to testify via Skype from Mexico. Defendant filed for reconsideration arguing that applicant should not be rewarded for unlawful actions because he was in the U.S. illegally and deported.

The WCJ recommended that reconsideration be denied noting that Reg. Section 10240 gives the WCJ discretion regarding whether an injured worker must appear at a hearing. Under Reg. Section 10241 a properly noticed trial on the merits may proceed even if the injured worker fails to appear. Due process requires the WCJ to provide the parties with a fair and open hearing. The WCJ pointed out that the applicant was “unavailable” for trial as defined in Evidence Code Section 240 and intended to pursue his rights. This allowed both applicant and defendant to present evidence and cross examine witnesses without causing prejudice to either party. The WCAB denied reconsideration and the petition for Writ of Review was denied.

22. COLA

La Count v. Los Angeles County Metropolitan Transit Authority (W/D) 80 C.C.C. 470

The applicant sustained an industrial injury on November 16, 2004 to his neck, back, left shoulder, left wrist, right hip, psyche and gastrointestinal system, as well as diabetes, hypertension and a sleep disorder.

Applicant was examined by three Agreed Medical Evaluators in orthopedic surgery, internal surgery and psychology. Applicant was also evaluated by vocational experts by both sides regarding his diminished future earning capacity.

The AME in orthopedic medicine stated that without the low back fusion the applicant was 100% totally disabled and found 20% nonindustrial apportionment. Using the strict AMA guides combined value chart the orthopedic whole person impairment was 49%. The Agreed Medical Evaluator also applying Almaraz/Guzman finding 8% cervical spine whole person impairment, 63% lumbar spine whole person impairment, 22% left upper extremity whole person impairment and 28% right hip whole person impairment. The WPI's totaled 121%, when added, or 80% using the combine value chart.

The treating physician agreed with the Agreed Medical Evaluator that applicant could not compete in the open labor market. The applicant did not wish to undergo surgical intervention for his left shoulder, lumbar spine and right hip.

The Agreed Medical Evaluator observed that the applicant had gained 100 pounds since the injury and had been termed unemployable by a vocational expert. The doctor opined that Almaraz/Guzman provides the most accurate rating approach and that he considered the applicant 100% totally disabled.

The internal and psychiatric AME's established the applicant sustained compensable consequence gastrointestinal and psyche injuries and both apportioned in accordance with Doctor Fetter's opinion. The AME in internal medicine indicated the applicant met the threshold for total disability.

The matter proceeded to trial on the issue of permanent disability and apportionment. The defendant argued for a strict application of the AMA guides while applicant argued for a total inability to compete in the open labor market. The WCJ agreed with the applicant. The WCJ concluded that the applicant was permanently totally disabled, reasoning that even after nonindustrial apportionment and using the combine value chart applicant's PD is 93%. The WCJ expressed reservation, however, about using the combined value chart as other than a guideline taking into account the AME's findings of a synergistic effect of the orthopedic disability, the WCJ ruled the permanent disability should be added rather than combined as expressed in the writ denied case of (Kite, 78 CCC 213) the WCJ alternatively used LC 4662 finding applicant 100% totally disabled in accordance with the fact.

The WCJ concluded that because the combine value chart is merely a guide, and there is sufficient evidence to support a finding of permanent total disability caused by this injury it is found that the injury caused permanent total disability after apportionment to nonindustrial causes.

The WCJ found a fee of \$148,148.68 after reconsidering his original fee award and suggesting use of a commutation based on a 4.6% yearly increase.

The WCAB upheld the WCJ but rescinded on the issue of attorney fee. The board rescinded the attorney fee award and remanded the matter for a newly-assigned WCJ (the original WCJ had retired) to make a new finding regarding a reasonable attorney fees and issue an appropriate award. The board noted the attorney successful performance in over 10 years a complex litigation, but saw no support for adding on a 4.6% yearly increase. The board reasoned that there is no basis for assuming a 4.6% annual increase in benefits pursuant to section 4659 (c) because the disability evaluation unit no longer uses that figure as a default assumption because recent history does not support it.

The WCAB indicated the WCJ should ask the DEU to provide an advisory commutation of attorney fees, based on, an annual State average Weekly Wage increase of 3%.

The WCAB affirmed the 100% award.

23. Privilege

City of Fresno v. WCAB (Tristan) (W/D) 80 C.C.C. 178

Applicant filed 14 separate applications alleging she had suffered various industrial injuries to various body parts and systems while employed by defendant.

Applicant also filed a petition pursuant to Labor Code 132a and an EEOC complaint, which resulted in a right-two-sue letter. Applicant did not file a discrimination-based suit against defendant.

Applicant issued a subpoena and defendant produce 673 pages of discovery records, declaring that the “attorney-client” privileged documents, had been withheld. Defendant submitted no privilege log regarding the documents that had been withheld.

The matter proceeded to hearing on the discovery issue. The WCJ indicated the discovery issue primarily involved stress, psyche and internal.

The WCJ issued a two-page discovery order that among other things directed a Human Resource Analyst employed by defendant, to appear for a deposition on a stated date and on other dates that could be coordinated between the parties.

Subsequently the WCJ ordered a second deposition to be conducted in the WCAB’s presence of the same person and ordered the production of certain witness statements. The Human Resource Analyst had obtained the related statements for applicant’s EEOC complaint.

According to the WCJ, the EEOC complaint asserted that the applicant had been treated differently because of applicant’s disability and that applicant had been subjected to harassment and different treatment by supervisory personnel and reassigned to a different position.

Defendant filed a petition for reconsideration from the second discovery order.

The WCJ recommended defendant’s petition for removal should be denied because defendants had not sought removal from the first discovery order. The WCJ noted that the events related to applicant’s EEOC complaint occurred at the same time that the applicant’s workers’ compensation claim of injury had occurred.

The WCJ added that the deposition had been scheduled and begun although it was without any benefit to the applicant since defendant had maintained that most of the subject matter was protected by either the attorney-client privilege or the attorney work product doctrine.

The WCJ also indicated the defendant had not been forthcoming in response to applicant's efforts through correspondence and subpoena to produce reasonably identified documents needed for discovery.

As to the claim that the witness statements were attorney client work product or entitled to the attorney-client privilege the WCJ indicated that the witness statements were requested by the Human Resource analyst and there was no evidence of attorney involvement in the production of the statements and therefore the statements would not be attorney work product or attorney-client privilege. In addition the WCJ indicated that obtaining the statements in anticipation of litigation would not qualify them for the privilege.

The WCJ also indicated that the defendant had waived any objection by not filing a petition for removal from the first discovery order and that the second discovery order covered essentially the same subject matter and therefore the waiver would apply.

The WCJ knowledge that defendant had produce 673 documents in response to a subpoena, but also noted that the custodian of records indicated the sum of the documents were withheld, yet no privilege log was prepared or produced, even though privilege had been claimed. The WCJ indicated those documents had been improperly withheld and should be produced immediately since no privilege log was produced.

The WCJ further indicated that applicant was entitled to discovery of documents that are reasonably calculated to lead to admissible evidence and that the administration of the workers' compensation case should be accomplish substantial justice. The WCJ concluded that defendant's actions of not providing discovery and not following reasonable and appropriate judicial orders was a serious encumbrance to the applicant.

The WCAB denied removal and adopted and incorporated the WCJ's report without further comment on the issues.

Defendant filed a writ of mandate contending that applicant was not entitled the statements taken by defendant in preparation for the defense of applicant's potential EEOC claim against defendant. The petition was denied. The court stated that the petitioner failed to demonstrate that the material ordered to be produced was prepared at the direction of counsel.

24. Post-Termination TTD

McFarland Unified School District v. W.C.A.B. (McCurtis) (W/D) 80 C.C.C. 199

Applicant sustained injury to his back while working for the employer during the period 7/1/2005 through 3/12/2013. Applicant was on modified duties until his employment was terminated due to a contract. There was no indication that applicant was terminated for cause. Applicant received severance pay. Applicant was unable to find employment in line with his work restrictions. He sought TTD benefits. The matter proceeded to trial and defendant argued that applicant was not entitled to TTD since applicant received 18 months of full salary as severance and that because applicant was only TTD due to his termination. The Judge found that the applicant was entitled to TTD from the time of his termination to the present and continuing. Stating that there was nothing in applicant's contract that waived defendant's obligation for TTD benefits and that the contract did not state that the settlement was salary continuation. The WCJ stated that applicant was TTD due to the industrial injury and not due to the termination. Defendant filed a petition for reconsideration.

The WCJ recommended that reconsideration be denied and reiterated that the applicant's inability to obtain other employment after his termination was not due to the termination but rather applicant's inability to find work within his work restrictions. There was no cause contributing to applicant's total inability to earn wages other than his industrial disability. The WCAB denied reconsideration and adopted and incorporated the WCJ's report. Writ was also denied.

25. Credit

Warner Bros. Studios, Inc. v. W.C.A.B. (Crocker) (W/D) 80 C.C.C. 308

Applicant sustained a CT to his back during the period 1/7/2007 to 1/7/2008 while working as a laborer. On 12/7/2012 the WCJ awarded TD for the period 1/7/2008 through 1/6/2010 less credit for time worked, payments made and for EDD benefits paid. The WCJ also awarded PTD commencing 2/18/2010. The F&A was affirmed on reconsideration and denied on writ. Applicant subsequently claimed penalties. Applicant asserted that defendant underpaid PD by \$17,356.34. Defendant claimed that since there was a TD overpayment that no further monies were owed. Applicant argued that the WCJ did not allow for a credit in the award against PD and that the WCJ had lost jurisdiction to amend his decision more than five years from the date of injury. The WCJ awarded penalties pursuant to L.C. 5814 as a result of the delay of payment of interest and attorney's fees on the 12/7/2012 award and awarded attorney's fees pursuant to L.C. 5814.5. The WCJ found that defendant did not underpay the 12/7/2012 PTD award by \$17,356.34. Defendant and applicant filed petitions for reconsideration. Defendant alleged that they had properly calculated and paid interest on the award and that the penalty per 5814.5 was excessive. Applicant alleged that the WCJ should have assessed penalty on the underpayment of \$17,356.34 because defendant could not take a credit that was not allowed in the original F&A. Further, that since it had been more than 5 years from the date of injury the WCJ did not have jurisdiction to alter his prior award. The WCJ recommended that both petitions be denied.

A majority of the WCAB panel concluded that defendant improperly took credit for overpaid TD and that defendant underpaid the award of PTD and therefore was liable for a penalty on the credit it improperly took. The WCAB affirmed the remainder of the decision.

The panel found that the WCJ did not allow a credit for TD against PD but defendants took the credit unilaterally but never raised the issue of credit at trial and did not present sufficient evidence to establish the overpayment. A defendant who unilaterally takes credit for an alleged overpayment may be liable for a penalty under L.C. 5814. Although the panel agreed that defendant should have been allowed a credit in the 12/7/2012 F&A, since no credit was awarded and the F&A was not challenged before becoming final, defendant was required to pay the award by its terms. Since defendant took a credit without seeking approval and failed to pay the full award the defendant was liable for a penalty. The panel also noted that even though defendant paid interest on the PD it was incorrect since PD was underpaid. Defendant filed a petition for writ of review which was denied.

REPORTED WCAB AND PANEL DECISIONS

26. Utilization Review

Rodriguez v. CIGA (BPD) 43 CWCR 13; ADJ 3415116

Applicant injured his neck and right arm in the course of his employment. The applicant developed psychiatric consequences.

A PQME in psychiatry indicated the applicant was not suicidal at the time of her evaluation in April 2008. She did not believe he needed full-time Healthcare Services, but if his condition changed, he should be hospitalized and his need for home care reassessed.

On May 17, 2011 the applicant told the QME that every few weeks he thought of taking his pills when his pain and depression got bad. His family kept the pills, however, and he did not know where they were.

The QME indicated he should have someone monitoring his medications but that he did not need full-time healthcare services because, although he did have suicidal thoughts, they were occasional any did not have access to the medications.

The primary treating physician concluded the applicant was not suicidal at this time however if he should become actively suicidal he will need 24 hour awake staff.

On May 13, 2013 the QME in orthopedic surgery reported the applicant had been hospitalized after disclosing his plans of jumping out of a moving vehicle to end his life. The physician recommended the applicant have full-time home healthcare services preferably by a psych technician or LVN. The physician added that the 24/7 home care assistance by a psych

technician or an LVN is reasonable and necessary to cure or relieve from the effects of the orthopedic injury. The physician submitted a request for authorization (RFA) for medical treatment on the required form.

The RFA submitted by the physician checked the box indicating the applicant faced an imminent and serious threat to his health and requested 24/7 home healthcare by a psych technician or LVN.

Defendant's utilization review sent a request for medical documentation to the QME on November 1, 2013. Five days later, a UR decision denying the requested home healthcare services issued.

The applicant filed for a hearing before the WCAB on the issue of need for home healthcare, whether the UR was timely and whether the finding that applicant needed the services was justified by the evidence.

A claims adjuster and her supervisor testified that the UR was not completed in 72 hours.

The WCJ found that the applicant sustained an injury as alleged, defendant's UR decision was timely but invalid, and applicant was entitled to the requested home healthcare services. The WCJ awarded benefits in accordance with the findings. Defendant filed a petition for reconsideration.

The WCAB with one Commissioner dissenting concluded that the WCJ decision was correct except for basing the finding that the UR was invalid on a reason other than it was untimely.

The majority pointed out that a UR decision is invalid only if untimely, citing *Dubon II*, (79 CCC 1298). The decision in the present case, issued nine days after defendant received the RFA would have been timely had it been for a regular UR determination. However, the physician had checked the box for imminent and serious threat and therefore pursuant to rule 9 92.9.1 (c) (3) (A) prospective or concurrent decisions shall be made in a timely fashion not to exceed 72 hours after receipt of the written information reasonably necessary to make the determination. The requesting physician must certify the need for an expedited review upon submission of the request. In this case the UR decision that issued on November 6, 2013 was therefore untimely.

The panel rejected defendant's contention that the RFA was not a valid prescription, observing that the prescription required by LC § 4600 (h) is either an oral referral, recommendation, or order for Healthcare Services communicated directly by a physician to an employer or its agent, or a signed and dated written referral, recommendation, or order by a physician for home healthcare services. (*Neri Hernandez*, 79 CCC 682)

The WCAB further concluded that the WCJ's findings were justified by the evidence in that all of the medical opinions agreed the applicant could not be unsupervised in the administration of his medication and all the physicians had recommended the home healthcare services.

The WCJ majority amended the findings of fact and order to find that the UR decision was untimely and affirmed the findings that defendant had received a prescription from home healthcare services, and that applicant was entitled to continuing home healthcare services.

27. QME

Bahena v. Charles Virzi Construction (BPD) 43 CWCR 41

The WCJ found the QME panel in the specialty of chiropractic was properly issued and that the DWC Medical Unit should not issue a second panel in the specialty of orthopedic surgery.

Defendants filed a petition for removal.

Applicant filed a claim which was denied by defendants. The denial was based on the fact the claim was filed more than one year after the alleged date of injury and there was no medical or factual evidence to support the claim. A fact sheet advising applicant about the QME process and a QME panel request form were enclosed with the denial letter.

Applicant mailed the request for a QME panel to the DWC Medical Unit requested a panel in the specialty of chiropractic. The request included a copy of the denial letter.

Defendant wrote to the Medical Unit objecting to applicant's panel request on the grounds the applicant did not provide evidence that a request for a medical evaluation pursuant to LC 4060 had been made.

That same day, defendant's attorney sent to applicant's attorney a letter stating that pursuant to LC 4060, a medical evaluation in the specialty of orthopedic is necessary, and that if the parties cannot agree on an AME within 15 days defendant will seek a QME panel.

Defendants then sent in their own form 106 requesting the medical unit issue a panel in the specialty of orthopedic surgery. The medical unit rejected the request because the panel in chiropractic had already been issued.

Applicant scheduled an evaluation with a chiropractor from the panel and defendant objected to the evaluation. The matter proceeded to expedited hearing.

The WCJ in his report and recommendation on removal stated that LC 4060 applies to disputes over compensability (where the entire claim is denied) and addresses the process for obtaining a medical evaluation to determine compensability.

Subsection (c) which refers to employees is represented by an attorney, states that on the medical evaluation shall be obtained through the procedure provided in section 4062.2.

4062.2 (b) states that no earlier than the first working day that is at least 10 days after the date of mailing of a request for a medical evaluation pursuant to 4060 or party may request the assignment of a three-member panel of qualified medical evaluators to conduct a comprehensive medical evaluation.

The ambiguity arises because LC 4060 (c) makes no reference to a request for a medical evaluation. Thus, it is not clear what triggers the 10 day waiting period that must expire before a party may request a QME panel in a represented employee cases.

The case presents two possible interpretations. Defendant contends that even though the requirement the parties attempt to agree on an AME was eliminated as part of SB 863, the requirement that a party seeking a QME panel first must send a letter to the other party, and then wait 10 days before requesting the panel remain in effect. This correspondence would not be a (request) per se, but would be a notification of that party's intention to request a panel in 10 days.

The WCAB indicated that defendant's position is the prevailing view among Worker's Compensation practitioners and is supported by the DWC website. The WCJ felt there were two flaws in the argument. First, section 4062.2 (b) specifically refers to a request for a medical evaluation pursuant to section 4060 and there is nothing in 4060 about a party notifying the other of its intention to request a QME panel before making the request. If the legislature did intend to include such a requirement in the statute it could have done so.

Second, there is no indication that when the requirement in section 4062.2 about proposing an AME was removed the legislature intended to retain (or replace it with) the provision that the party seeking the evaluation notify the other party of its intention to request a QME panel. In fact, legislative history of SB 863 suggests the legislature may have intended to do away with the requirement of a second letter after the denial letter in represented employee cases before a QME panel can be requested.

The other possibility is the request for a medical evaluation pursuant to section 4060 refers to the notice in section 4060 (d) whereby the employee requests a comprehensive medical evaluation to determine compensability or that the employer has not accepted liability and the employee may request a comprehensive medical evaluation to determine compensability. The form of requesting a QME panel must accompany the notice per subsection (e).

Also, when a claim is denied the employer must provide the pamphlet explaining how to request a QME evaluation. They must also provide the fact sheet. There is no requirement that either party send a letter to the other notifying of its intention to request a QME panel before making the request.

The WCJ concluded that the change in enacted by SB 863 regarding obtaining a comprehensive medical evaluation for represented employees in denied injury cases was intended to bring that

process more in line with the procedure for unrepresented employees. In those cases, QME panel may be requested by the employee immediately upon receipt of the denial letter, and by the employer 10 days later if the employee does not request the panel.

No second letter notifying the opposing party of its intention to obtain a panel is required, nor is there any reason for one.

Once a denial letters issued, a medical evaluation is required to determine compensability, no purpose is served by holding up that process until one party sends a letter to the other to initiate the process.

Eliminating the requirement that a party requesting a QME panel propose an AME, but retaining the requirement that a letter must be sent an additional 10-day waiting period must pass before a panel can be requested, does nothing to streamline the current process eliminate unnecessary delays. Allowing parties to request a panel QME 10 days after the denial letter issues would achieve that goal.

Based on these arguments the WCJ found that the request made more than 10 days after the new denial letter was sent satisfied the requirements of the statutory framework.

The WCJ recommended that removal be denied and the WCAB issued an order denying removal.

28. MPN

Shawl v. Arrowood Indemnity (BPD) 43 CWCR 61

Applicant sustained an admitted injury. A Worker's Compensation Judge issued a Findings and Award in August 2007, including a finding that the applicant is in need of future medical treatment.

Applicant elected and treated with a Primary Treating Physician. In December 2011 the DWC approved defendants MPN. Defendant implemented its MPN March 1, 2012.

In a pretrial conference statement dated August 27, 2012 defendant stipulated that applicant's PTP was his current treating physician who was not within the MPN. The case was never set for hearing.

In June 2013 defendant wrote applicant to inform him that his medical care was being transferred into the MPN. Applicant continued to treat with the same PTP he had treated with following the findings in August 2007.

In May 2014 applicant filed for an expedited hearing on applicant's right to continue to treat with his current PTP who was not within the employer's MPN.

In December 29, 2014, a WCJ found that defendant had properly transferred applicant's care into the MPN in-as-much as defendant informed the applicant of the MPN and provided him sufficient time to choose an MPN physician.

The judge also found that the alleged 2012 PTP stipulation had never been accepted because the parties never moved forward to trial on any issue then presented. Applicant filed a timely petition for reconsideration. WCAB reversed the WCJ's decision.

The WCAB found that the stipulation made at the MSC is binding and that the board cannot relieve a party from the stipulation absent good cause. The board ruled that defendant entered into a binding involuntary stipulation.

The WCAB also observed that rule 9767.9 (a) expressly recognizes that the employer may authorize treatment by a provider outside of its MPN regardless of whether the injured worker meets one of the four conditions described in the section (acute condition, chronic condition, terminal illness, surgery).

In the instant case, the majority concluded that the stipulation entered into by the parties was made after the implementation of defendant's MPN and constituted an effective authorization for applicant to treat outside the MPN.

The majority cited the significant panel decision in Patterson (79 CCC 910) for the rule that to be relieved of its stipulation, defendant must show good cause or present evidence of a change in applicant circumstances. In this case the majority concluded that defendant had failed in both respects.

The majority also invoked a preference for an efficacious physician-patient relationship to aid the success of medical treatment.

Accordingly, the majority ruled the defendant was liable for self-procured treatment sought by the applicant for the treatment with the PTP he was treating with before the MPN was established.

A dissenting Commissioner citing the case of Babbitt v. Golden Eagle Insurance Company (72 CCC 70), for the proposition that defendants have a right to transfer an injured worker's care into their MPN regardless the date of injury or the date of a future medical care award. The commissioner found no reason to distinguish the present case in which the board rejected the argument that a prior stipulation to care with a non-MPN physician and award of future medical care prevented defendant from transferring care into the MPN. The dissenting Commissioner reasoned that because MPN status made only a procedural change in the law by allowing provision of reasonable medical treatment through an MPN, and did not affect any substantive rights of the employees, they could be applied retroactively to prior awards and stipulations.

Further the commissioner went on that the argument that a defendant is obligated to show cause or a change in the applicant's circumstance or condition to transfer medical treatment into the MPN was specifically rejected in Babbitt.

It Babbitt the dissenting Commissioner pointed out the board stated that they do not find an employer or insurer must demonstrate that there is been a change of condition or defective or incomplete medical treatment for transferring injured employees care into an MPN.

The dissenting Commissioner stressed that the Babbitt case had held the board could not add limitations to defendant's right to transfer care into its MPN.

29. Permanent Disability

Hanker v. City of Stockton (BPD) 43 CWCR 91

Applicant, a police officer, suffered a cumulative injury to her heart. The applicant suffered from a rapid abnormal heart-beat originating in the upper chambers of the heart. Applicant's condition caused her extreme fatigue and made it difficult for her to function during the day.

The applicant was offered two treatment options by her treating cardiologist. One treatment was medications and the other was ablation procedure. The applicant underwent cardiac catheterization with no ultimate alteration of her condition. With drugs the applicant could only be expected to maintain her current debilitated status and their side effects included fatigue, lethargy, dizziness and heart palpitations 2 to 3 times a week.

The Qualified Medical Evaluator opined the applicant had an 80% WPI with the medication regime. The physician recommended the applicant undergo the ablation procedure which is not a surgical procedure but may be considered invasive.

Although the applicant was faced with a serious life-threatening injury applicant refused to undergo the ablation procedure. The WCJ found injury to the heart applying the presumption of LC 3212.5.

The WCJ found the defendant had met the burden of proof under LC 4056 by making an unequivocal tender of medical treatment that will reduce applicant's permanent disability to zero and applicant refused the treatment without good cause. The WCJ indicated the risk of such treatment would be inconsiderable in view of the seriousness of the injury. The WCJ found the applicant suffered zero permanent disability and was entitled to further medical treatment. Applicant filed a petition for reconsideration.

The WCAB affirmed the WCJ's decision agreed with the judge that defendant had met their burden of proof for the application of LC 4056.

The WCAB observed that LC 4056 places the burden of proof on defendant to show that (1) applicant's refusal to undergo the medical treatment was unreasonable (2) that a defendant must demonstrate that they made an unequivocal tender of medical treatment (3) that applicant refused to submit to the treatment without good cause and (4) the risk of the procedure was inconsiderable in view of the seriousness of the injury and the procedure would reduce disability to a certain extent.

In this case the parties stipulated that defendant had made an unequivocal offer of the treatment, the QME stated the success rate for an initial ablation procedure is 80%, with very little risk of totality, and second such procedure, also with an 80% success rate, may be undertaken if the first is not successful. Thus, the risk may be deemed inconsiderable in view of the seriousness of applicant's injury and the significant potential of curing her heart condition and leaving her with no permanent disability. In sum, such facts support the finding that applicant's refusal to undergo the treatment is unreasonable.

The WCAB citing the case of Department of Health Services v. Superior Court (31 Cal.4th 1026) stated that under the circumstances specified in LC 4056, an employee's failure to take reasonable steps to avoid further injuries can provide the employer with a partial or complete defense to a workers' compensation claim.

While injured workers are certainly free to refuse treatment without cause, section 4056 obviously was adopted to protect employers by making certain that workers will be returned to the labor market as quickly as possible. It is the plain purpose of the statute to prevent employees with treatable injuries from resorting to unfounded beliefs, unfounded fears or personal idiosyncrasies or convictions to reject proffered treatment.

The WCAB agreed with the WCJ that the balance between the risks and benefits of the ablation procedure tilted in favor of the procedure, and therefore affirmed the WCJ's decision.

30. IMR

Garibay-Jimenez v. Santa Barbara Medical Foundation (BPD) 43 CWCR 92; ADJ 6552734

The applicant's attorney filed an appeal of an IMR decision denying his client surgery on the grounds the IMR reviewer did not see the AME reports. The WCAB granted reconsideration and remanded the matter for a new IMR determination because the defendants failed in their duty to provide all relevant medicals to the IMR reviewer and therefore the Administrative Director decision was in excess of the AD's powers and therefore a new IMR was required.

Please also note the IMR appeal went to a WCJ first and then to the WCAB.

The WCJ denied applicant's petition appealing the decision of the Administrative Director upholding the Independent Medical Review determination which sustained a Utilization Review denial of recommended surgical treatment in the form of left ulnar nerve decompression.

The WCJ held that the applicant failed to establish a statutory basis for her appeal and that applicant neglected to provide the Agreed Medical Evaluator reports in response to the IMR request for medical records. The WCJ further held that it would be unreasonable to require defendant to pay for an additional IMR determination.

Applicant appealed the IMR determination on January 8, 2015, contending that pursuant to LC § 4610 (h) (1), that the determination was the result of a plainly erroneous express or implied finding of fact, which mistake of fact as a matter of ordinary knowledge based on the information submitted for review pursuant to section 4610.5, not a matter subject to expert opinion.

The reasons cited by the applicant were the failure of both the UR and IMR physicians to review the reports of the Agreed Medical Evaluators who recommended nerve decompression and post-operative physical therapy.

The WCJ concluded that it was applicant's failure to timely forward the medical reports that prevented the IMR reviewer from considering the AME reports, such that any error on the part of IMR was self-inflicted by the applicant. The WCJ concluded that the error was caused by applicant's oversight an inadvertence and it would be unreasonable to force defendants to provide another IMR determination.

The WCAB stated that Labor Code § 4610.5 (l) places a mandatory obligation on the employer to forward all relevant medical records to IMR. Further Administrative Director Rule 9792.10 .5 also mandates the IMR organization shall receive from the claims administrator all reports of the physician relevant to the employer's current medical condition including reports specifically identified in the request for authorization.

The WCAB went on to state there is no statutory or regulatory obligation placed on the applicant to submit medical records to the IMR organization.

Therefore, defendants failure to provide the relevant medical records to the IMR organization constitute grounds for appeal of the IMR determination, under Labor Code § 4610.6 (g) and(h) which provide in (g) The determination of the independent medical review organization shall be deemed to be the determination of the administrative director and shall be binding on the parties; (h) a determination of the administrative director pursuant to this section may be reviewed only by a verified appeal from the medical review determination of the administrative director, filed with the Appeals Board for hearing and served on all interested parties within 30 days of the date of the mailing of the determination to the aggrieved employee or the aggrieved employer. The

determination of the administrative director shall be presumed to be correct and shall be set aside only upon clear and convincing evidence of one or more the following grounds of appeal, (1) the administrative director acted without or in excess of the administrative director's powers.

By failing to provide the IMR reviewer with all the material and relevant medical records, the determination of the IMR organization, and that is the Administrative Director, was enacted without or in excess of its powers. The IMR process can only work if the parties meet their obligations to provide the necessary medical records.

The WCAB granted reconsideration and rescinded the findings and return the matter for a new IMR application. The WCAB further found that defendant failed to comply with its obligation under Labor Code 4610.5 (1) to provide all relevant medical records to the IMR organization, making the final determination of the independent medical review organization an act without or in excess of the administrative director's powers.

31. Discovery

Aguilar v. Harris Ranch (BPD) 43 CWCR 177

This case did not allow applicant's deposition to go forward pursuant to Labor Code 3208.4 regarding history of sexual harassment and assault and instead limited discovery to medical records only.

LC 3208.4 states that in any proceeding under this division involving an injury arising out of alleged conduct that constitutes sexual harassment, sexual assault, or sexual battery, any party seeking discovery concerning sexual conduct of the applicant with any person other than the defendant, whether consensual or nonconsensual or prior or subsequent to the alleged act complained of, shall establish specific facts showing good cause for that discovery on a noticed motion to the appeals board. The motion shall not be made or considered at an ex parte hearing. The procedures set forth in Section 783 of the Evidence Code shall be followed if evidence of sexual conduct of the applicant is offered to attack his or her credibility. Opinion evidence, evidence of reputation, and evidence of specific instances of sexual conduct of the applicant with any person other than the defendant, or any of such evidence, is not admissible by the defendant to prove consent by or the absence of injury to the applicant, unless the injury alleged by the applicant is in the nature of loss of consortium.

The WCJ issued a discovery order allowing defendant to depose applicant on her history of sexual harassment. The WCAB rescinded the WCJ's order allowing defendant to depose applicant on her history of sexual harassment and assault, and instead, limited discovery to medical records only. The WCAB concluded that in claims such as applicant's involving sexual harassment, assault or battery, Labor Code §3208.4 requires that defendant set forth specific facts showing good cause for discovery regarding past sexual history such that defendant's right

to discovery and due process is balanced with applicant's right to privacy. What is discoverable is determined on a case-by-case basis. If good cause is shown the request for discovery must be provided in the least intrusive way possible.

In this case the WCAB found that defendant sought to depose applicant on past sexual history prior to obtaining any evidence establishing that such discovery was directly relevant to applicant's psychological state and, therefore, the discovery request was premature.

The board concluded that the good cause requirement was not satisfied simply by defendant's argument that applicant's sexual history may be relevant to causation and apportionment. Although defendant did not meet its burden of proof to compel applicant's deposition testimony of questions related to past sexual abuse, Labor Code § 3208.4 did not shield applicant from having to prove her case under Labor Code §3208.3 (b) by establishing by a preponderance of evidence that actual events of employment were predominant as to all causes combined of her psychiatric injury.

32. Apportionment

Pattiz v. State Compensation Insurance Fund (BPD) (43 CWCR 201):

The applicant sustained two industrial injuries. The first was a cumulative trauma injury to his left shoulder, cervical spine and lumbar spine. The second injury was a slip and fall which resulted in a loss of consciousness in a claim of injury to his head, lumbar spine, cervical spine, neurological system and left shoulder.

The parties obtained to Agree Medical Evaluators. The first AME, in orthopedics, indicated the applicant had a prior left shoulder injury. The physician indicated the applicant never recovered from those injuries. The physician apportioned 90% of the left shoulder permanent disability to nonindustrial pre-existing factors and 10% to the continuous trauma. For the lumbar spine the applicant had a prior lumbar surgery. The physician apportioned 50% of the permanent disability to the specific injury 40% to nonindustrial factors and 10% to the continuous trauma. For the cervical spine he apportioned 80% to the fall and 20% to the continuous trauma. As to permanent disability the physician for the lumbar spine gave a 20% WPI, for the cervical spine he gave a 5% WPI and for the left shoulder an 11% WPI. The orthopedic AME later a changed his opinion on apportionment to the left shoulder and apportioned 80% of the disability to pre-existing and 20% to the cumulative trauma. The AME in neuropsychology apportioned all the disability to the specific injury. He found 28% WPI related to the traumatic brain injury.

Applicant and defendant both obtained vocational experts. The applicant's vocational expert concluded that applicant could not perform competitive work and that was thus permanently totally disabled. The expert did not address apportionment. The defense vocational expert

identifying multiple positions applicant could perform and thus opined the applicant had 49.4% diminished future earning capacity.

The matter proceeded to trial on the issues of permanent disability, apportionment and future medical treatment in both cases. The WCJ issued a joint findings of fact and award in which he found that the specific injury caused permanent total disability and that the continuous trauma injury caused periods of temporary disability. He did not apportion between the two dates of injury or to nonindustrial causes.

Defendants filed a petition for reconsideration. The WCAB granted reconsideration and remanded the case to the trial level for a new decision on permanent disability and apportionment. The WCAB first cited Labor Code 4663 and the Escobedo case for the principle that permanent disability must be apportioned to causation.

The board went on to state that based on Benson where permanent disability arises from separate industrial injuries, there must be a separate determination of the cause of disability from each injury. This rule requires the board in each case make separate determination of the law and fact in a separate award of permanent disability. The WCAB observed the undisputed evidence established that applicant's neuropsychological permanent disability was solely caused by the specific injury.

The orthopedic Agreed Medical Evaluator included apportionment for the applicant's left shoulder, cervical spine and lumbar spine between the two dates of injury. The orthopedic AME had not advised that the two injuries were inextricably intertwined, making it impossible to separately determine the PD for each injury. The board pointed out that applicant's vocational expert had failed to address apportionment of permanent disability between the two injuries and nonindustrial factors.

The WCAB then went on to issue guidelines when the matter was returned to the trial level. The board indicated that as to the left shoulder substantial evidence supported the findings of the Agreed Medical Evaluator. The board indicated as to the lumbar spine the WCJ found the report of the Agreed Medical Evaluator speculative. The panel noted however the apportionment opinion was based on applicant's self-reported lumbar surgery prior to the industrial injury as well as ongoing pain complaints in the medical records. The panel directed the WCJ to address the opinions and issues and issue a new opinion on apportionment. The panel did not address the cervical spine apportionment since none had been made to nonindustrial causes.

The panel next concluded that the trial judge's decision not to apportion between the industrial and nonindustrial causes in light of Labor Code § 4662, which applies when the totality of circumstances support a finding of 100% permanent total disability was incorrect. The Board stated the WCJ did not address evidence of apportionment because he concluded there is no legal basis for apportionment when total permanent disability is determined in accordance with fax

pursuant to section 4662 (b). The WCAB observed there are four situations, under Labor Code § 4662 (a) in which permanent disability is conclusively presumed total. Labor Code § 4662 (b) provides that in all other cases, permanent total disability shall be determined in accordance with the fact.

Where the four presumed total permanent disability situations are not at play, the permanent disability is not conclusively presumed to be total. Permanent disability is subject to apportionment based on its causation, including in cases where the injured worker's overall permanent disability is 100%.

The WCAB overturned the WCJ's finding of 100% without apportionment and remanded the matter to the trial level. The panel ordered that the WCAB make a separate determination of permanent disability for each claim and that the WCJ address evidence of apportionment between the two dates of injury and to nonindustrial causes.

33. QME

Morales v. Robert Half International, Inc. (BPD) 2015 Cal. Work. Comp. P.D. LEXIS 200

The applicant initially alleged industrial injury to her neck and right shoulder. The employer accepted the injury. The applicant amended her claim to include internal, neurological, psychiatric and gynecological. Applicant filed a petition for issuance of multiple QME panels in several specialties to evaluate her claim. The WCJ issued an order allowing QME panels in those four specialties. The defendant filed a petition for removal.

The WCAB held that before an applicant may request assignment of multiple QME panels, there must be a determination by a treating physician substantiating injury to an alleged body part and a timely objection to the report.

The WCAB found that because the defendant accepted the neck and right shoulder, LC 4062 and LC 4062.2 were applicable. The WCAB explained that before an applicant could request the assignment of additional panels of QME (s), there must be a determination made by a treating physician and an objection by either party to it. The WCAB found that there was no report by a treating physician that would substantiate the applicant's claim of injury to body parts in the fields of internal medicine, neurology or gynecology.

The WCAB concluded that the defendant would sustain irreparable harm and substantial prejudice, because there was no basis for the WCJ to order additional QME panels.

34. Utilization Review

Minh Ly v. Loral Space Systems (BPD) 2015 Cal. Wrk. Comp. P.D. LEXIS 138

On June 6, 2011 it was found that the applicant sustained industrial injury to his head, neck, and psyche while employed by defendant on April 13, 2001 causing 100% total permanent disability and need for medical treatment.

Applicant requested medical treatment in the form of the prescription drug Lyrica. Applicant request was authorized by defendant as well as refills were authorized by defendant. Applicant again requested a refill of Lyrica which was submitted to UR. The UR denied the request. Following denial the applicant filed for an expedited hearing.

The WCJ ordered the matter off calendar instead of proceeding to an expedited hearing to address defendant's contention that defendant improperly denied medical treatment by not authorizing the prescription medication Lyrica. The WCJ concluded that the treatment dispute was subject to a timely utilization review and the matter was outside of the WCJ's jurisdiction.

Applicant filed a petition for removal.

The WCAB pointed out that the medication was continuously prescribed and approved by defendant until the pending issue arose. Applicant's attorney cited the Patterson case arguing that defendant was obligated to continue providing the Lyrica as it had in the past and in the absence of a change in applicant's condition or circumstances. Defendant responded that the WCJ was correct because the UR was timely conducted and all medical disputes are subject to utilization review and independent medical review.

The WCJ in her report indicated that Patterson did not apply as that case dealt with the nurse case manager for which there was no need for an ongoing prescription. Here, with respect to the Lyrica medication, there was a need for prescription and each prescription was therefore subject to an RFA and UR. The WCAB indicated that the matter could proceed to an expedited hearing on the issue regarding Patterson. In Patterson it was held that the employer could not unilaterally cease providing nurse case manager services because there were earlier authorized to help address the complicated medical treatment issues. The panel in Patterson reasoned that the earlier authorization remained in effect in the absence of evidence of a change in the employee's circumstances or conditions showing that the service of a nurse case manager was no longer reasonably required. It was not necessary for applicant's physician to initiate a request for authorization for submission to UR by defendant before challenging the termination of the nurse case manager services at issue in that case. The panel expressly held that the use of an expedited hearing to address the medical treatment issue raised by the applicant was authorized by section 5502 (b) (1).

The WCAB then concluded that not allowing the applicant to be heard following the filing of his declaration readiness to proceed for an expedited hearing is contrary to due process, and all parties in a workers' compensation proceeding are entitled to due process. This is because raising and determining issues without providing the affected parties an opportunity to be heard, as

occurred in this case, is contrary to due process. In order to properly consider an issue consistent with the party's rights to due process evidence is to be received on the record along with any objections and arguments. This assures that the issues and evidence are properly identified, that there is a proper record and meaningful opportunity for further review of the WCJ's decision if it is sought. The WCAB granted removal and rescinded the WCJ's order and returned the matter for an expedited hearing in a new decision based upon the record created at the hearing. In a footnote to the decision of the board indicated they were expressing no opinion on whether the holding in the Patterson case has application in this case.

One commissioner dissented agreeing with the WCJ's finding that the matter should be ordered off calendar.

35. Utilization Review

Derosa v. Fremont Compensation (BPD) 48 CWCR 38

On October 14, 2013, a secondary treating physician, requested authorization for spinal surgery for the applicant. Defendant issued a utilization review denial on October 23.

The matter proceeded to expedited hearing at which the applicant contended that the UR denial was untimely. The WCJ ruled that the treatment request did not comply with AD rule 9785 and defendant's UR denial was timely and timely communicated. Therefore, the WCJ did not order defendant authorize the requested treatment. Applicant filed a petition for reconsideration.

The WCJ recommended that reconsideration be denied as the WCJ concluded UR denial was timely. The WCJ observed that the UR denial had issued on October 23, after defendant's receipt of the RFA on October 17, within the timeframe mandated by LC §4610, five working days from receipt of the treatment requests. The WCJ found the RFA inadequate. Further the WCJ wrote that the UR reviewer had made two unsuccessful attempts to reach the physician by telephone but never got through. The written UR denial had been addressed to applicant's attorney with copies sent to the secondary treating physician, defense counsel and applicant.

The WCAB concluded that a secondary treating physician's surgical treatment request can be valid. The panel reasoned that either a primary or secondary physician may make a request for authorization of treatment, noting that LC §4610.5 authorizes either the treating physician or the physician designated by the treating physician to render opinions on all medical issues necessary to determine eligibility for compensation. The primary or secondary physician is authorized to make an RFA.

Concerning the timeliness of the communication of the UR decision to the requesting physician the panel citing both to Dubon and Bodham stated there are three crucial requirements for UR decision to be timely. (1) a UR decision must have complied with all time requirements,

including time limitations within the UR decision must be communicated; (2) a timely made UR decision is rendered on timely but not been timely communicated; (3) when a UR decision is untimely and thus invalid, the WCAB may determine, based on substantial evidence, the necessity of medical treatment at issue.

A UR decision is due within five working days from receipt of all information necessary for a determination of medical necessity, but not later than 14 days from the date the physician sought treatment. However the panel continued, Labor Code § 4610 (g) (3), imposes additional requirements;(1) that the UR decision must be communicated to the treating physician within 24 hours by telephone, fax, or email, and (2) written notice of the decision must be sent to the treating physician, the injured employee, and, if represented, the injured employee's attorney, within two business days after it his issued.

The panel emphasized that even when a UR decision has been made within a shorter time frame than required by the Labor Code the time for communicating the UR decision starts running from the date on which the UR decision is actually made.

In the instant case, the defendant has the affirmative burden of proving that the communication was timely and that both the 24-hour and two business-day requirements were met. The panel observed that the UR denial indicates the UR physician placed calls to the treating physician on October 21, 2013 and October 23, 2013 and that the receptionist transferred the call to the voicemail of one Jessica and that the callback information was provided along with the reason for the call. Nevertheless, the panel reasoned, defendant had not shown when the denial was communicated or whether it was timely communicated. Further, the denial was viewed as having been communicated on October 21, written notice should have been sent by October 22. The WCAB remanded the matter to the trial level to determine whether the UR was timely.

36. MPN

Lescallett v. Wal-Mart (BPD) 2015 Cal. Wrk. Comp. P.D. LEXIS 196

The applicant sustained injury to the neck, right shoulder and right knee on July 6, 2010. The applicant selected a physician outside the MPN.

The matter proceeded to hearing on medical control on the issue of whether the applicant was obligated to select a primary treating physician within the MPN.

The applicant selected a primary treating physician in the field of pain management. There was no physician available within 15 mile or 30 minute radius of applicant's home or workplace in the area of pain management.

The WCAB concluded that if an injured employee chooses to select as his or her primary treating physician specialist whose specialty is appropriate to treat common injuries experienced by

injured employees based on the type of occupation or industry in which employee is engaged, defendant's MPN will satisfy access standards in rule 9767.5 if the MPN includes at least three physicians in the medical specialty whose medical offices are within 15 mile or 30 minute radius of applicant's residence or workplace.

The applicant's choice of pain management specialist was appropriate to treat her injury, and because defendant's MPN did not meet access standards to accommodate applicant's choice, applicant is entitled to select a pain management specialist as her primary treating physician outside defendant's MPN.

The majority of the WCAB rejected defendant's position that applicant's selection of pain management "specialist" as her primary treating physician triggered application of access standard in 8 Cal. Code Reg. § 9767.5 pertaining to specialists, which requires that a specialist be within 30 miles or 60 minutes of applicant's home or workplace. The WCAB reasoned that Labor Code § 4616.3(d) states that selection by an injured employee of a treating physician and any subsequent physicians shall be based on the physician's specialty or recognized expertise in treating the particular injury or condition in question," that while MPN regulations define "primary" and "secondary" physician, they do not distinguish between "primary treating physicians" and "specialists" nor do they provide sufficient guidance as to type of medical specialty reasonably expected for each type of occupation and industry since this varies in each case, that access standards applicable to specific physicians chosen by an injured employee depends on whether the physician is employee's primary physician who is selected by the employee to be responsible for his or her ongoing care or a secondary physician who provides some treatment but is not primarily responsible for continuing management of care, regardless of type of medical specialty they practice, because every physician that provides MPN treatment is required to have specialty or expertise necessary to provide treatment for employee's particular condition, and that, consistent with Labor Code § 4616.3(d) and 8 Cal. Code Reg. §§ 9767.5(a) and 9785(a), which instruct both employer and employee that primary treating physician should be appropriate specialist or expert, relevant regulations defining "primary treating physician" do not preclude applicant's selection of pain management physician as her primary treating physician.

Commissioner Lowe dissented from the majority panel and found that if applicant chooses a specialist as her primary treating physician, defendant's MPN will satisfy access standard in 8 Cal. Code Reg. § 9767.5 if MPN includes at least three physicians in that specialty located within 30 mile or 60 minute radius of applicant's residence or workplace, because, Commissioner Lowe reasoned, while applicable statutory and regulatory scheme for implementation of MPNs do not preclude injured worker from selecting a specialist as his or her primary treating physician, regulations require a specialist who has been selected as primary treating physician to operate under rules applicable to specialists, and the conclusion reached by the WCJ and majority would render access standards for specialists irrelevant.

37. Penalties

Hernandez v. State Fund (BPD) 43 CWCR 11

The applicant was injured in the course of his employment.

The applicant retained a vocational expert to testify regarding permanent disability. The WCJ directed defendant to pay \$5230.20 pursuant to LC § 5811 as costs to the vocational expert. Defendant filed a petition for reconsideration from the order awarding costs which was denied. The defendant failed to pay the vocational vocational expert fee that was ordered. At a MSC defendant agreed to pay the vocational fee that had been ordered and did in fact pay the fee.

The applicant's attorney filed a petition for an attorney fee for \$1900 based on 4.75 hours of legal services at the rate of \$400 an hour. Defendant agreed to pay 4.45 hours at \$300 an hour.

A status conference was held and three days later the attorney (now is a lien claimant) increased the claim to \$3420 to include his time in connection with the Mandatory Settlement Conference. Defendant paid \$1335. The matter proceeded to hearing and the WCJ awarded lien claimant \$4000 as reasonable attorney fee pursuant to LC § 5814.5 for enforcement of payment of the earlier award of LC §5811 costs. In his opinion the WCJ wrote that he computed the fee based on an hourly rate of \$400 and noted the total fee could have been as much as \$5600 had defendant not already paid \$1335. Defendants filed a petition for reconsideration. The WCAB agreed with the WCJ.

The board indicated that the Labor Code provides that when payment of compensation has been unreasonably delayed or refused subsequent to the issuance of an award by the employer that has secured payment of compensation pursuant to section 3700, the Appeals Board shall, in addition to increasing the order, decision, or award pursuant to section 5814, allow reasonable attorney fees incurred in enforcing the payment of compensation awarded. The panel then noted that it was undisputed that defendant unreasonably delayed payment of the award of LC § 5811 costs.

The question was whether the board could consider only the time spent before defendant paid the costs or whether they could also consider the amount of time spent litigating the proper amount of the LC § 5814.5 fee. The WCAB indicated that the amount of time spent litigating the fee should be considered in determining the LC §5814.5 fee. The board citing the En Banc decision in Ramirez (73 CCC 1324), LC § 5814.5 fees are themselves the penalty for unreasonable failure to pay an award. The purpose of the LC §5814.5 attorney fee penalty is to encourage prompt payment of awards, encourage attorneys to continue representing injured workers after the award and to compensate attorneys for enforcing delayed awards. A defendant should not be able to decide unilaterally what constitutes a reasonable LC § 5814.5 feet.

The panel rejected defendant's argument that the \$400 hourly rate was excessive and that the travel time was excessive. The WCAB noted that the board decisions during clearly establish that a \$400 hourly fee was reasonable for an attorney lien claimant a certified specialist with over 45 years of experience. The board further ruled that travel time can include not only the time spent in actual travel but also the time expended in parking and the like. The WCAB affirmed the WCJ.

38. Rating

Ramirez v. Space Lok (BPD) 43 CWCR 61; ADJ1242171

Applicant sustained injury to his left shoulder, wrist, thumb, neck and psyche on 7/23/2012. He underwent two surgeries and never regained full strength and movement in his left thumb and fingers. PQME Segil found the impairment difficult to rate under the AMA Guides and used the "grip loss" method finding an 18 percent WPI. He stated at depo "I don't think one percent impairment would be a common sense whole person impairment". The WCJ rejected the doctor's finding observing that the doctor had not provided an AMA Guides rating and based his Almaraz/Guzman application on "common sense". The WCJ issued rating instructions in line with a strict application of the AMA Guides rating applicant's total PD for multiple body parts at 36%. The WCAB granted applicant's petition for reconsideration.

The WCAB reversed the WCJ. The panel stated that the Almaraz/Guzman methodology allows physicians to depart from the strict application of the AMA Guides where cases "do not fit neatly into the diagnostic criteria and descriptions" Physicians may exercise discretion in accordance with their clinic judgment to find the most accurate discretion of impairment. However, the doctor must remain within the "four corners" of the guides. The WCAB cited Blackledge to explain the relationship between substantial evidence and medical opinions. Under Blackledge if the condition is not covered by the Guides the physician compares measureable impairment resulting from the non-covered condition to the measurable impairment resulting other conditions with similar impairment of function in performing ADLs.

The WCJ cannot disregard a medical expert's conclusion when the conclusion is based on expertise in evaluation of the significance of medical facts. The panel concluded that Dr. Segil's 18 percent impairment for the thumb was adequately supported by evidence of applicant's medical history. Measuring impairment via grip strength is within the four corners of the AMA Guides. The WCAB reversed the judge and applied the higher standard.

39. IMR

Saunders v. Loma Linda University Medical Group (BPD) 43 CWCR 145; ADJ8107354

Applicant submitted an RFA. Defendant timely sent applicant's request to utilization review and timely communicated the results of utilization review. The applicant filed for Independent Medical review. The Independent Medical review was not timely conducted.

The WCJ majority contrary to the Arredondo case concluded that the time requirements of Labor Code § 4610.6 must be construed as mandatory in order to uphold the basic constitutional and statutory provisions of workers' compensation law, as well as the purpose of time frames for completion of Utilization review and Independent Medical review. Those time frames are designed to provide prompt provision of medical care to an injured worker.

The panel majority concluded that Labor Code § 4610.6 (d), which states that the IMR organization shall complete IMR within specified time frames is mandatory. The WCAB held that the remedy for untimely IMR would be the same as an untimely UR. The WCAB ruled that once the IMR is untimely the WCAB would have jurisdiction over the medical treatment issue and could award medical treatment if it is based on substantial evidence.

The dissenting Commissioner concluded the IMR determination in this case is valid even if it did not issue within the time frames in Labor Code § 4610.6 (d). The dissenting Commissioner reasoned that the legislature requires medical treatment disputes to be evaluated through IMR in order to assure that medical necessity is objectively and uniformly determined based on the Medical Treatment Utilization Schedule, and other recognized standards of care. The dissenting Commissioner indicated an IMR determination is a governmental action performed under the auspices and control of the Administrative Director, distinctly different from Utilization Review where the defendant is obligated to perform within the statutory and regulatory time frame. The legislature provided guidelines in Labor Code §4610 (d) addressing when an IMR determination should issue, but it enacted no provision that invalidates the IMR determination if the determination is not made within the Labor Code § 4610 (d) time frames. Untimeliness is not listed as a ground for IMR appeal in Labor Code § 4610 (h) and given the express legislative intent and statutory design of IMR, Labor Code § 4610.6 (d) time frames are directory and not mandatory.

40. Second Opinion

Bautista v. Arlon Graphics (BPD)2015 Cal. Wrk. Comp. P.D. LEXIS 654

The applicant sustained an admitted industrial injury to his ribs, pulmonary system, lumbar spine and right ankle in the course of his employment. The applicant also claimed industrial injury to his psyche and sleep disorder. Applicant elected a primary treating physician within the

employer's MPN. The applicant credibly testified to symptoms of anxiety which he verbalized to the primary treating physician. The primary treating physician failed to diagnose anxiety or refer applicant for an opinion on the issue of psychological treatment to a psychologist or psychologist.

After trial the WCJ indicated that the treating orthopedist had not made a diagnosis of anxiety and the court found a referral for a second opinion to a psychologist would not be the appropriate referral for a second opinion. It seems as though if applicant is not satisfied with the diagnosis from the primary treating physician, the orthopedist, he should seek a second opinion from an orthopedist as to whether treatment for anxiety as indicated or whether applicant should be referred to a psychologist. To find otherwise would circumvent the second opinion process. To find applicant could seek a second opinion from a psychologist would not be in the spirit of the legislative intent. This would allow the injured worker to refer out to the various specialties independently instead of going through the primary treating physician.

Applicant sought reconsideration or removal of the Findings and Order of the WCJ that referral to a psychologist pursuant to Labor Code § 4616.3 and 4616.4 is not appropriate at this time. The WCJ ordered the applicant to attend the scheduled appointment with his primary treating physician and further ordered the parties to draft an interrogatory to the primary treating physician to address the issue of diagnosis of anxiety and whether referral for psychological consult and treatment is reasonable and necessary.

To find the applicant may use a psychologist for a second opinion would be exceeding the courts authority and power. The court found the most efficient way to resolve this issue is to directly ask the treating doctor if applicant needs a referral for treatment for anxiety. The applicant testified that the primary treating physician thought he should be treated for the anxiety. If the treating physician finds the applicant in need of such a referral this would resolve the dispute. If the primary treating physician does not find applicant requires referral to a psychologist, then applicant could obtain a second opinion from an orthopedist.

Applicant filed a petition for reconsideration asserting that he may utilize the second and third opinion process as set forth in Labor Code 4616.3 to obtain a second opinion from a psychologist. The court found the use of the second and third opinion process was not appropriate at this time and that applicant should maintain his appointment with the primary treating physician and asked that the physician comment on the need for psychological medical treatment. Applicant contends that Labor Code section 4616.3 and A.D. rule 9767.7 entitled him to obtain a second opinion from a physician he selected and defendant's medical provider network. The WCAB dismissed the petition for reconsideration and the petition for removal.

