

DWC EDUCATIONAL CONFERENCE

CASE LAW UPDATE

2014

The opinions expressed herein are not the opinions of the State of California, the Department of Industrial Relations, the Workers' Compensation Appeals Board, the Div. of Workers' Compensation or other Judges. They are the opinions of the presenter only. Each case is different and must be evaluated on its own merits.

TABLE OF CONTENTS

1. The Regents of the University of California v. WCAB(Lappi).....	3
2. Young v. WCAB.....	4
3. Lantz v. WCAB.....	6
4. Benavides v. WCAB.....	8
5. Garcia v. WCAB.....	9
6. Navarro v. City of Montebello.....	9
7. Hernandez v. Geneva Staffing, Inc.....	11
8. Brower v. David Jones Construction.....	14
9. Dubon v. World Restoration.....	15
10. Patterson v. The Oaks Farm.....	19
11. Torres v. Contra Costa Schools Insurance Group	21
12. Bodam v. San Bernardino County.....	22
13. San Diego Unified School District v. WCAB(Robledo).....	24
14. NBC Universal Media v. WCAB(Moussa).....	25
15. New Axia Holdings v. WCAB(Martinez).....	26
16. Monterey County Superior v. WCAB(Martinelli).....	27
17. Solano v. WCAB.....	27
18. County of San Bernardino v. WCAB(Foroughi).....	28
19. Fetner v. City of Long Beach.....	29
20. Morris v. WCAB.....	29

21. Castro v. U.S. Fire Insurance	30
22. Villalobos v. Bright Horizons Family Solutions.....	31
23. Evans v. San Joaquin Regional Transit District.....	32
24. Rodriguez v. Zenith.....	33
25. Avila v. Associated Pacific Construction.....	34
26. Gomez v. County of Los Angeles.....	35
27. Porter v. City & County of San Francisco.....	35
28. Razo v. Las Posas Country Club.....	36
29. Bertrand v. County of Orange.....	37
30. Garcia v. Alameda Unified.....	37
31. Tallent v. Infinite Resources.....	38
32. Robertson v. Bonnano.....	39
33. Solis v. Ameron.....	39
34. Acosta v. Balance Staffing.....	40
35. Chott v. Safety National Casualty.....	42
36. Franco v. California Business Forms.....	43
37. Stock v. Camarillo State Hospital	44
38. Franco v. Clougherty.....	45

COURT OF APPEAL CASES

1. Evidence

The Regents of the University of California v. WCAB (Lappi)(Court of Appeal published) 79 C.C.C. 509

Applicant was injured in 2003 and in 2007 made additional claims for aggravation of the underlying injury. Applicant requested all unprivileged documents from the claims examiner. The WCJ ordered the depo and to produce all non-privileged portions of the claims file. The University produced a privilege log. At deposition the claims examiner produced the claims file including computer notes identified as "Notepad detail". However, he produced none of these notes for the period after 1/11/2008 when the University retained counsel. Lappi made a further demand for the documents which the University refused to produce claiming privilege. On 2/28/2012 the WCJ ordered the University to file a copy of computer Notepad detail with the WCJ for an in camera review of the notes. The University did not object to that order and, in fact, complied with it. On 5/1/2012 the Judge returned the claim notes to defendant and ordered defendant to review the claim notes and serve any and all unprivileged email notations on applicant. The defendant was also to provide a log of any withheld information. In response the University prepared a privilege log in which it identified 205 documents it claimed to be privileged. Lappi objected to 49 of those documents. The case went before the Judge At trial the University agreed that 2 documents were not privileged. This left 47 still in dispute. After trial the Judge concluded that 11 of the 49 documents in dispute were protected from disclosure.

The University filed for reconsideration which the WCAB deemed to be a removal since it was not from a final order. The WCAB rescinded the WCJ's order and returned the matter to the WCJ to appoint a special master who would conduct an in camera review of the disputed documents. Once the special master provides a report to the WCJ a new decision should be issued. Defendants filed a petition for writ of review which was granted.

The court looked at two issues: 1) do the attorney-client privilege, the absolute work product doctrine and evidence Code Section 915 operate within workers' compensation proceedings and 2) can the WCAB order an in camera review of documents in order to determine whether the attorney-client privilege or the absolute work product doctrine apply despite evidence code section 915.

Section 915 states that "the presiding officer may not require disclosure of information claimed to be privileged under this division or attorney work product under ...in order to rule on the claim of privilege..."Lappi argued that the privilege had already been waived since defendant had already produced the documents. The court found that under E.C. Section 912 a waiver of privilege must be voluntary and since the earlier production was in response to the WCJ's order

it is not deemed voluntary. E.C. Section 919 states that any privileged information erroneously...required to be disclosed by the presiding officer in a proceeding is inadmissible.

Lappi then argued that E.C. Section 915 does not apply in Workers' compensation proceedings. He relied on Labor Code Section 5708 which states that "the WCAB shall not be bound by common law or statutory rules of evidence and procedure". The court found that when it comes to the treatment of privileged information the Evidence Code trumps the Labor Code. They found that Evidence Code Section 910 explicitly overrides any other statute which might otherwise be viewed as limiting application of the rules of evidence. The court concluded that although the WCAB is free to adopt Rules of Practice and Procedure which ignore the rules of evidence it remains bound by the statutory requirements for dealing with privilege found in the Evidence Code, including Section 915. The court annulled the WCAB's order to the WCJ to appoint a special master. The matter was returned to the WCAB with directions.

2. AOE/COE

Young v. W.C.A.B. (Court of Appeal published) 79 C.C.C. 751

Sergeant Daniel Young, the petitioner here, was initially hired in 1994 as a jail booking officer by the Department.

In 1999 Young was promoted to correctional sergeant, the same position he held when he sustained his injury.

Pursuant to Departmental Order No. 3004, issued in February 2004, correctional officers, including correctional sergeants, are required to "maintain themselves in good physical condition so that they can handle the strenuous physical contacts often required of a law enforcement officer." The job description stated: "Work occasionally involves personal danger, and exposure to hazardous, uncontrollable and life-threatening situations This position may require walking, running, lifting and climbing during efforts to catch or subdue hostile individuals."

Correctional sergeants were also required to complete periodic training exercises each year, many of which involve physical activity. Despite requirements to maintain good physical condition, the Department did not provide officers with an opportunity to exercise or participate in a fitness regimen during work hours; nor did the Department provide guidance as to the types of exercises or activities considered appropriate for maintaining the requisite level of fitness. As such, Sergeant Young maintained his physical fitness through his own fitness regimen at home when off duty.

On January 9, 2012, Sergeant Young was doing his usual warm-up calisthenics, specifically jumping jacks. During one of the jumping jacks, Young came down and felt "extreme stabbing pain in his left knee." Young testified he has "serious questions as to whether or not he would

have been healthy enough to perform his duties without his exercise regimen”. The workers’ compensation judge (WCJ) concluded that Sergeant Young’s injury was compensable under section 3600(a)(9),

The WCAB disagreed that such a belief was objectively reasonable under a mere “general requirement” to maintain fitness, and annulled the WCJ’s decision. The court of appeal issued a writ of review.

The court utilized the Ezzy test from *Ezzy v. W.C.A.B.* This is a two prong test: (1) the employee subjectively believes his or her participation in the [injury-producing] activity is expected by the employer, and (2) the belief is objectively reasonable. The question in this case is if the second prong of the Ezzy test is met. The court reviewed multiple prior cases in their analysis as to the applicability to law enforcement personnel.

The court ultimately concluded that the second prong of the Ezzy test was satisfied because Sergeant Young’s belief—that the Department expected him to engage in warm-up calisthenics as part of an off-duty exercise regimen—was objectively reasonable as a matter of law. There must be a “substantial nexus between an employer’s expectations or requirements and the specific off-duty activity in which the employee was engaged”. Although these departmental directives required correctional sergeants to maintain good physical condition and a certain physical ability, the Department does not provide correctional sergeants with an opportunity to exercise or maintain a fitness regimen during work hours; nor does the Department provide guidance as to the types of exercises or activities considered appropriate for maintaining the requisite level of fitness. Accordingly, it is objectively reasonable for Sergeant Young to believe that the Department expected him to engage in an off-duty exercise regimen to maintain his physical fitness. The Department does require correctional sergeants to undergo periodic training exercises, which often involve physical activity that can be “extremely strenuous.” That court held that it would be reasonable for correctional sergeants to believe the Department expected them at least to maintain sufficient cardiovascular health to pass the training exercises.

The court stated “To allay any concerns law enforcement departments may have about potentially increased liability as a result of this decision, we note that departments have the ability to limit the scope of potential liability by designating and/or preapproving athletic activities or fitness regimens as the police department...”

Sergeant Young’s injury was found compensable under section 3600(a)(9)’s exception for coverage. Accordingly, the WCAB’s decision was annulled and the matter remanded.

3. Going and coming rule

Lantz v. WCAB (Court of Appeal published) 79 C.C.C. 488

Lieutenant Seth Patrick Lantz, a 33-year-old correctional officer at Pleasant Valley State Prison in Coalinga, California, was killed in an automobile accident at 6:20 a.m. on 10/2/10. Lantz had worked at Pleasant Valley State Prison near Coalinga, California for approximately two years before the accident. . He continued to live in the Bakersfield area and commuted to the prison in his own vehicle. The one-way commute was over 85 miles. Lantz worked as a program lieutenant. Lantz regularly worked 40 hours per week. On Friday, October 1, 2010, Lantz worked his regularly assigned shift. Sometime after the start of his shift and before the meal break at 4:00 p.m., Lantz was informed that he would need to “hold over” and serve as the watch commander for the next shift, which ran from 10:00 p.m. to 6:00 a.m. At about 9:00 p.m., Lantz spoke with his wife by telephone and told her that he was being held over. At 6:00 a.m. on October 2, 2010, Lantz’s wife received a text message from him stating that he was on his way home. Applicant drove his own vehicle and did not transport any state property except for a protective vest. Applicant was involved in a car accident and killed during his commute home after completion of the second shift.

Applicant’s widow and four children filed for workers’ compensation benefits. In April of 2012 the matter proceeded to trial. The Judge found that the applicant sustained injury arising out of and in the course of employment. He did not find that the going and coming rule applied. On reconsideration the WCAB reversed the Judge applying the going and coming rule and finding that the “special mission” exception did not apply. A petition for writ of review was filed and denied by the appellate court. A petition for review was filed with the Supreme Court who issued directions to grant the writ. In June 2013 the appellate court issued the writ.

The court reviewed the going and coming rule and the standing that excluded from benefits of the workers’ compensation act are all those accidental injuries which occur while the employee is going to or returning from his work... The going and coming rule has numerous exceptions which are often called “special or extraordinary circumstances”. There are three exceptions within that: 1) the special mission exception 2) the special risk exception 3) the required vehicle exception. This case concerned the special mission exception. The special mission exception provides that an injury suffered by an employee during his regular commute is compensable if he was performing a special mission.

“The special mission exception requires three factors to be met: (1) the activity is extraordinary in relation to the employee’s routine duties, (2) the activity is within the course of the employee’s employment, and (3) the activity was undertaken at the express or implied request of the employer and for the employer’s benefit. Only the first prong is in dispute because the parties

agree that Lantz performed the hold-over shift as watch commander within the course of his employment, at the employer's request, and for the employer's benefit.

The court went through an extensive discussion on the standard of review. Indicating that the court could only review questions of law not fact. Ultimately the court determined that the issues presented were questions of law and not fact and therefore appropriate for review.

The court then analyzed the special mission exception. The inquiry into whether an activity was extraordinary typically involves the consideration of three fundamental factors—the location, hour, and nature of the work to be performed by the employee.

The additional shift did not affect the distance or the route of his commute home. The additional shift only changed when Lantz drove home, it did not require an extra trip. The special mission exception ordinarily does not apply when the only special component is the fact that the employee began work earlier or quit work later than usual. Here, the fact that Lantz did not make an extra trip, when coupled with the fact that procedures were in place for allocating additional shifts to personnel already on site, weigh against the assignment being deemed extraordinary.

The court stated that it is possible to infer that doubling an employee's workday is extraordinary in some circumstances. The court concluded that the evidence in the record regarding the length of Lantz's additional shift and how additional shifts are assigned supports conflicting inferences.

As to the third fundamental factor—the nature of the work performed compared to Lantz's routine duties—the court determined that the record contained conflicting evidence on at least one relevant point. In addition, conflicting inferences can be drawn from the evidence that is not contradicted. The court found that there was contradictory evidence as to the number of employees Lantz supervised during the second shift.

The court stated "Because Labor Code section 5952 limits judicial scrutiny of the evidence to whether the WCAB's decision is supported by substantial evidence and expressly prohibits a reviewing court from "exercis[ing] its independent judgment on the evidence" , we must view the evidence in the light most favorable to the WCAB's decision. (See Cal. Cas. Ind. Exch. v. Ind. Acc. Com., supra, 21 Cal.2d at p. 760 [court must "indulge in all reasonable inferences to support the commission's findings"].)

The court further concluded that the WCAB decided questions of fact when it decided that the duties of watch commander were not extraordinary in comparison to Lantz's routine duties as a lieutenant.

Consequently, they reject applicants' argument that the course of employment issue posed a question of law. Instead, the WCAB decided a question of fact.

The last inquiry in the analysis was whether the WCAB's decision was supported by substantial evidence. They concluded that the testimony of Lieutenant Contreras and Captain Walker about the operation of the prison, the job of lieutenant, and the job of watch commander of first shift constituted substantial evidence that supported the finding of fact that serving a hold-over shift as watch commander was not an extraordinary activity for Lantz.

The court upheld the decision of the WCAB. The parties to bear their own costs.

4. Petition to Re-open

Benavides v. WCAB (Court of Appeal published) 79 C.C.C. 483

Applicant worked as a roofer and sustained injury on 2/7/2005 to his ankle and back when he fell from a roof. On 5/9/2008 the applicant had an abnormal EMG of the lower extremities. On 7/23/2008 the parties entered into a stipulated award for 51% based on the AME report of Dr. Sohn who had issued a report on 4/12/2007. On 2/8/2010 applicant filed a petition to reopen. As a result applicant was re-evaluated by Sohn on 12/28/2010 who increased the applicant's rating based on the abnormal EMG, which he did not have to review at the time of his prior evaluation and report.

The parties took Dr. Sohn's deposition in which he testified that applicant's disability increased based on the abnormal EMG study. Sohn stated that applicant's condition had begun to decline prior to the award based on the EMG.

The matter proceeded to trial on 7/9/2012 and the Judge found no new and further disability. Applicant filed a petition for reconsideration. The Judge then vacated his decision and issued a new decision finding the applicant has permanent partial disability of 72%. Defendant filed a petition for reconsideration. The board overturned the Judge's decision finding that the applicant had no new and further disability since the disability occurred prior to the award. Applicant filed a petition for writ of review which is granted by the appellate court.

The court looked at the law on this issue. Section 5803 accords the appeals board continuing jurisdiction to rescind or revise its awards, "upon good cause shown." Such cause may consist of newly discovered evidence previously unavailable, a change in the law, or "any factor or circumstance unknown at the time the original award or order was made which renders the previous findings and award 'inequitable.'

An award based upon a stipulation may be reopened or rescinded if the "stipulation has been 'entered into through inadvertence, excusable neglect, fraud, mistake of fact or law, or where special circumstances exist rendering it unjust to enforce the stipulation.'"

When the Judge approved the award the Judge was unaware that applicant's condition was much worse and when the doctor saw the applicant he did not have the EMG studies to properly

determine applicant's condition. The court found that whether the stipulation was the result of inadvertence, excusable neglect, or mistake of fact, the error justifies reopening the resulting award. The stipulated award was inequitable.

The court went on to find that substantial evidence does not support the appeals board's decision to deny the petition to reopen.

The decision of the WCAB was annulled and the case was remanded with directions to reinstate the award of 72%.

5. MPN

Garcia v. WCAB(Court of Appeal unpublished) 79 C.C.C. 619

Applicant was injured due to a slip and fall on 8/8/10. She treated with multiple doctors, none of whom were in the MPN. Applicant treated with one MPN doctor, Dr. Saucedo. The matter was heard for trial. Based on the en banc decision of *Valdez v. WCAB* the WCJ determined that the applicant had a 2% disability based on the reporting of Dr. Saucedo. The Judge also excluded the medical reports of the non MPN providers. The applicant filed a petition for reconsideration which was denied by the board.

A petition for writ of review was filed and accepted by the appellate court. The appellate court reviewed the holding in *Valdez v. WCAB*. In *Valdez* the Supreme Court limited its review to those matters arising out of the IMR process under L.C Section 4616.6. Pursuant to 4064 "no party is prohibited from obtaining any medical evaluation or consultation at the party's own expense and all ...medical evaluations...shall be admissible in any proceeding before the appeals board..."

The case was remanded with directions for the judge to rule upon the admissibility of the excluded reports and any other reports the applicant wished to introduce.

EN BANC AND SIGNIFICANT PANEL DECISIONS

6. Panel QME

Navarro v. City of Montebello (en banc) 79 C.C.C. 418

The WCAB ruled the Labor Code does not require an employee to return to the same panel QME for evaluation for an injury that occurred subsequent to the initial evaluation and the requirement in rule 35.5 (e) that an employee shall return to the same evaluator when a new injury or illness is claimed involving the same parties and the same type of body parts is invalid because it is inconsistent with the Labor Code.

The WCAB initially issued a notice of intention to make this ruling and is now followed by the actual decision.

The WCAB pointed out that LC 4062.3 (k) provides that if, after a medical evaluation is prepared, the employer or the employee subsequently objects to any new medical issue, the parties, to the extent possible, shall use the same medical evaluator who prepared the previous evaluation to resolve the medical dispute.

There is no reference in LC 4062.3 (k) to subsequent claims of injury.

LC 4067 states that if the jurisdiction of the Appeals Board is invoked pursuant to LC 5803 on the ground that the effects of the injury have recurred, increased, diminished, or terminated, a formal medical evaluation shall be obtained. The subsequent additional formal medical evaluation shall be conducted by the same AME or QME, unless the WCJ has made a finding that he or she did not rely on the prior evaluators formal medical evaluation, any party contested the original medical evaluation by filing an application for adjudication, the unrepresented employee hired an attorney and selected a qualified evaluator to conduct another evaluation pursuant to (b) of section 4064, or the prior evaluator is no longer qualified or readily available to prepare a formal medical evaluation.

The WCAB pointed out that neither LC 4062.3 (k) nor LC 4067 contains a reference to subsequent claims of injury, and reasoned that the Labor Code requires that all medical-legal evaluation be obtained as set forth in LC 4062.1 or 4062.2, and the evaluator must discuss all medical issues arising from all reported claims of injury at the time of an evaluation and an employee is generally required to return to the original evaluator in a new medical issue arises in the same claim of injury and when an employee reopens the same claim.

The WCAB saw no requirement that an employee return to the same evaluator for subsequent claim of injury, nor any provision that distinguishes between procedures for a valuation of claims of injury based on the same or different body parts.

WCAB concluded there was no requirement that an employee return to the same evaluator for a subsequent injury.

The WCAB next concluded the requirement of rule 35.5 (e) that the employee return to the same evaluator when a new injury or illness is claimed involving the same type of body parts and the parties are the same was inconsistent with the cited statutes and was therefore invalid.

The WCAB affirmed the WCJ's order finding that the applicant could obtain a new QME or AME for an injury that occurred subsequent to the original AME or QME examination.

7. Home Health Care

Roque Neri Hernandez v. Geneva Staffing, Inc. (en banc) 79 C.C.C. 682

On May 30, 2013, a workers' compensation administrative law judge (WCJ) issued a Findings and Award (F&A), which found that applicant was entitled to medical treatment in the form of home health care services beginning on August 3, 2011 and continuing and awarded applicant payment for self-procured home health care services. Defendant sought reconsideration and contended that newly enacted Labor Code sections 4600(h) and 4603.2(b)(1) applied.

While employed as a machine operator for defendant, applicant sustained a severe crush injury to his right dominant hand on July 11, 2011. Applicant was treated by hand surgeon Charles Lee, M.D. Applicant had three surgeries on his hand. He developed a serious infection in his hand, which necessitated a fourth surgery on September 19, 2011. Then, on December 20, 2011, he had a fifth surgery. Hand surgeon Leonard Gordon, M.D., acted as the Agreed Medical Evaluator. , Dr. Gordon concluded that: As it stands at this point, Mr. Neri-Hernandez has essentially lost all use of the right upper extremity.”

Applicant was cared for at his home by his spouse. A handwritten note on St. Mary's Medical Center letterhead dated November 11, 2011 by Dr. Lee stated in its entirety that: “To Whom it may Concern, This is to notify that Neri Hernandez Roque has been under the care of Dr. Charles K. Lee for severe injury to his right hand since 7-11-11 at which time he has needed constant care from his wife Adrianna Bayona. “Mr. Neri Hernandez will need continuous care as his ongoing treatment goes on. If you have any questions please call our office at Pros at (415)750-55-88.

On March 5, 2013, the parties appeared for an expedited hearing on the issue of home health care services. Applicant sought an order for home health care services provided by his spouse; an award “for retroactive payment . . . to the date of injury payable to the applicant as a medical benefit;” and attorney's fees. Defendant contended that the November 11, 2011 report by Dr. Lee was not a valid prescription for home health care services as it did not specify the type of care or number of hours of care. Applicant's spouse testified. On May 30, 2013, the WCJ issued the F&A. He found that applicant was entitled to payment “for self-procured medical care” beginning on August 3, 2011. He awarded services for 24 hours per day, 7 days per week from August 3, 2011 to November 4, 2012, and for 6 hours per day, 7 days per week from November 5, 2012 and continuing, and attorney's fees of 15%. He awarded payment based on applicant's spouse's regular hourly rate of pay at a day care center. Defendant sought reconsideration. On August 12, 2013, an Appeals Board panel granted defendant's Petition for Reconsideration, rescinded the F&A and returned the matter to the WCJ. However, on August 16, 2013, the panel granted reconsideration of its August 12, 2013 Opinion in order to further review the case.

The board re-iterates the text of Labor Code Section 4600(h), 5307.8 and 4603.2(b)(1). Section 4600(h) makes clear that home health care services are included in the definition of “medical treatment,” but it also limits an employer’s duty to provide that treatment by imposing two additional conditions which are part of an injured worker’s burden of proof. The first condition requires that home health care services be prescribed by a physician, and an employer may become liable for home health care services provided 14 days prior to receipt of a prescription. The second condition requires that an employer’s liability for home health care services is subject to either section 5307.1 or section 5307.8. Section 5307.1 applies where an official medical fee schedule or Medicare schedule covers the type of home health care services sought. When the type of services sought is not covered by an official medical fee schedule or Medicare schedule, section 5307.8 applies.

The WCAB held Sections 4600(h), 4603.2(b)(1), and 5307.8 apply to requests for home health care services in all cases that are not final regardless of date of injury or dates of service. based on the language in section 84 of SB 863, as of January 1, 2013, the provisions of sections 4600(h), 4603.2(b)(1), and 5307.8 became applicable to any pending case, except cases that were “final” subject only to the Appeals Board’s continuing jurisdiction under sections 5803 and 5804.

Section 4600(h) and the related statutes do not define the meaning of “prescribed” and the Labor Code does not contain a definition of a “prescription.” Accordingly, since the applicable definition of a physician is contained in the Business and Professions Code, they used the definition of a prescription in the Business and Professions Code. Business and Professions Code section 4040 states in pertinent part that: “(a) ‘Prescription’ means an oral [or] written . . . order that is both of the following: (1) Given individually for the person or persons for whom ordered that includes all of the following: (A) The name or names and address of the patient or patients; . . . (C) The date of issue; (D) Either rubber stamped, typed, or printed by hand or typeset, the name, address, and telephone number of the prescriber, his or her license classification . . . (F) If in writing, signed by the prescriber issuing the order . . . [and] (2) Issued by a physician . . . ” (Italics and bolding added.) Based on this definition, in the context of home health care services a prescription is issued by a physician and is an oral order for a patient or, a written order identifying the patient, with the date, the name and address of the prescriber, and the signature of the physician. Hence, an oral or written communication which meets the minimum requirements is sufficient to meet the condition in section 4600(h) that home health care services be prescribed. Thus, they held that the prescription required by section 4600(h) is either an oral referral, recommendation or order for home health care services for an injured worker communicated directly by a physician to an employer and/or its agent; or, a signed and dated written referral, recommendation or order by a physician for home health care services for an injured worker.

An injured worker must prove that the prescription was received by the employer and the date on which it was received. This receipt requirement narrows an employer's duty to pay for medical treatment because an employer's liability is limited to 14 days before the date that the prescription was received. Liability is not based on the date that the need for services may have begun. Section 4600(h) does not specify how an employer must receive the prescription before it may become liable for care and does not require that the prescription be submitted by an injured worker. Under other circumstances when an employer receives other notice that home health care services may be needed or are being provided, an employer has a duty under section 4600 to investigate. An employer also has a regulatory duty to conduct a reasonable and good faith investigation to determine whether benefits are due.

The second condition in section 4600(h) provides that an employer's liability for home health care services is subject to section 5307.1 or section 5307.8. Where no official medical fee schedule or Medicare schedule covers the type of services sought, then section 5307.8 applies. 5307.8 requires that "the administrative director shall adopt ... a schedule for payment of home health care services". To date no schedule has been adopted. The second provision states that: "No fees shall be provided for any services, including any services provided by a member of the employee's household, to the extent the services had been regularly performed in the same manner and to the same degree prior to the date of injury. The third provision allows "an attorney's fee for recovery of home health care fees under this section Hence, a reasonable attorney's fee based on the recovery of section 5307.8 home health care services may be sought by an applicant's attorney.

In its Petition, defendant contended that an award of home health care services should be denied because applicant's spouse did not submit an itemization of services pursuant to section 4603.2(b)(1). Section 4603.2(b)(1) is not part of an injured worker's burden of proof under sections 4600(h) and 5307.8. Instead, section 4603.2(b)(1) concerns payment. Section 4603.2(b)(1) does not impose a separate reporting requirement or a separate procedure for obtaining authorization, but merely shifts the duty to the provider who is seeking payment to include those documents as appropriate.

Dr. Lee's November 11, 2011 note evidenced his opinion that applicant needed assistance from his spouse. Moreover, applicant's spouse's un rebutted and unimpeached trial testimony established that she performed home health care services for applicant. Thus, with respect to defendant's first contention that applicant's award of home health care services was not supported by substantial medical evidence, without considering any other issues, the WCJ properly found that the evidence before him showed that applicant was and is in need of home health care services.

The November 11, 2011 note from Dr. Lee states that applicant has been under the care of Dr. Lee "for severe injury to his RT. hand since 7-11-11 at which time he has needed constant care

from his wife Adriana Bayona.” The note is dated, is in writing and is signed. . They concluded that the note was a prescription for home health care services within the meaning of section 4600(h). Defendant “received a prescription” as required by section 4600(h) and at a minimum, defendant’s potential liability period began 14 days prior to the date it received the letter and the prescription.

The WCJ awarded payment to applicant’s spouse at her previous earnings rate based on what he assumed were the number of hours recommended by Dr. Lee and Dr. Gordon retroactive to August 3, 2011. Any award of reimbursement would be based on an appropriate rate for a similar caregiver and would not be based on a spouse’s loss of earnings from previous employment. Thus, they rescinded the Findings and Award. The WCAB concluded that further record development was needed. The matter was returned to the WCJ.

8. COLA

Brower v. David Jones Construction (en banc) 79 C.C.C. 550

Applicant sustained injury on 12/20/2005 to his back, knee and psyche while working as a foreman. Defendants paid TD through 12/20/2007 pursuant to LC 4656. However, defendants mistakenly continued paying TD through 1/31/2008 when defendants began paying PD at \$270 per week.

The parties utilized Dr. Newton as an AME in neurology. Dr. Newton, throughout numerous reports found the applicant to be PTD. The parties utilized Dr. Perez as an AME in psychology who found the applicant had a 0% disability from a psychiatric standpoint. Applicant’s treating psych disagreed and found the applicant significantly disabled. The applicant was also evaluated by a voc expert whose report opined that the applicant had lost 100% of his future earning capacity.

The case proceeded to trial on 12/10/2012 on the issue of PD, date in which PTD should commence the start of the COLA, attorney’s fees and med/legal expenses. The WCJ awarded PTD based on the AME Newton and the treating psychologist. The WCJ also awarded PTD commencing on 10/6/2011 which the WCJ found to be the applicant’s P&S date.

Defendant’s filed for reconsideration and this en banc decision was issued. The WCAB upheld the finding of 100% permanent total disability finding that the reporting of Dr. Newton and the reporting of Dr. Russell as well as the reporting of Scott Simon, the voc expert, was substantial evidence and properly relied upon by the WCJ.

The WCAB then looked at when the applicant’s PTD should begin. Historically PD benefits were not payable until the employee reached P&S status. However, under SB 899 the legislature placed a 104 week cap on TTD. Further the legislature amended 4650 to require that PD

commence when the last payment of TDI has been made pursuant to 4656. Section 4650 requires that PD be paid to an applicant who may be TTD. Since the amount of PD may be unknown the code requires that PD be paid based on a reasonable estimate. The court therefore held that when the injured worker becomes P&S and is determined to be permanently totally disabled defendant shall pay PTD retroactive to the date its statutory obligation to pay TDI terminated pursuant to LC Section 4650. If a defendant paid PPD to an applicant who becomes PTD the defendant must retroactively adjust the PD payments to the correct rate.

The court then looked at the COLA adjustment. LC 4659 allows for an increase in the life pension and PTD indemnity for all injuries occurring after 1/1/2003. In *Baker v. W.C.A.B* 76 C.C.C. 701 the Supreme Court found that COLA's be calculated and applied prospectively commencing on January 1 following the date on which the injured worker first becomes entitled to receive and actually begins receiving such benefit payments. However, the Baker court expressly excluded post SB-899 injuries from its holding.

Under SB 863, for some injured workers, PD would not be due until an award. And since SB 899 PD may be due before an applicant is found P&S. Even for those workers who are not entitled to PD until an award is issued the amount then due shall be calculated from the last date for which TDI was paid, or the date the employee's disability became P&S, whichever is earlier.

Therefore, the court held, that an injured worker's COLAs commence on the January 1 after the injured worker became entitled to receive PD without regard to the indemnity rate or whether the employer actually paid PD. In this case they found that applicant became entitled to receive PTD on 12/21/2007 and therefore the COLAs commence on 1/1/2008. The issue of attorney's fees was deferred since the change in commencement of the COLA would affect the attorney's fee.

9. Utilization Review/IMR

Jose Dubon v. World Restoration, Inc. (en banc) 79 C.C.C.313; 79 C.C.C. 566; 79 C.C.C. 1298

The WCAB held as follows:

1. A utilization review decision is invalid and not subject to independent medical review only if it is untimely.
2. Legal issues regarding the timeliness of a UR decision must be resolved by the Worker's Compensation Appeals Board, not IMR.
3. All other disputes regarding a UR decision must be resolved by IMR.

4. If a UR decision is untimely, the determination of medical necessity may be made by the WCAB based on substantial medical evidence consistent with LC § 4604.5.

Applicant's treating physician requested authorization for back surgery as well as authorization for various post-surgical services. SCIF submitted to the matter to utilization review. Utilization review was performed by Dr. deGrange, a board-certified orthopedic surgeon, who denied the authorization for the surgery and the post-surgical services as not medically necessary.

Nothing in the record reflected that the UR physician reviewed the report of the AME, the discogram report, the lumbar MRI, the EMG/NVC study or other medical reports. The primary treating physician invoked the internal UR process. A second UR denial was issued.

Applicant filed an IMR application and a DOR for an expedited hearing asserting that the UR denial was defective, because among other things, there was insufficient medical review.

The expedited hearing took place and the issues that were raised were need for further medical treatment and whether IMR is the exclusive remedy per section 4610.5. The WCJ issued a decision holding the dispute over claimed procedural defects in defendants UR denial must be resolved through IMR. The WCJ stated that the failure of the UR reviewing physician to review all the relevant medical records was a critical error. Applicant filed a petition for reconsideration.

The WCAB granted reconsideration and issued an en banc decision in Dubon I in February of 2014. SCIF filed a petition for reconsideration of that decision. The WCAB granted reconsideration for further study. Subsequently on October 6th of this year the WCAB rescinded their prior decision and issued a new decision. (Dubon II)

The WCAB began by reviewing the legislative history of UR and IMR.

Following that review they conclude that a UR decision is invalid and not subject to IMR only if it is untimely. The WCAB indicated that the Supreme Court in Sandhagen (73 CCC 981) found that section 4610 requires that every employer shall establish a utilization review process in compliance with this section. To be in compliance with section 4610, there are certain procedural requirements that shall be met, including that a UR decision shall be made within specified deadlines. As used in the Labor Code shall is mandatory and language.

Where a UR decision is not timely rendered in compliance with these mandatory deadlines, there is no dispute for IMR to resolve within the meaning of section 4610 (g) (3) (A) and (B) and section 4610.5 (a), (b), and (k). Citing the case of Elliott v. WCAB (Court of Appeal, 75 CCC 81) a dispute does not legally arise unless the employer does utilization review in a timely fashion. The Supreme Court in Sandhagen concluded based on a review of the legislative history that a defendant must conduct UR with respect to an employer's request for treatment and that this UR must be timely.

Accordingly, the Board found that where a defendant's UR decision is untimely, it is invalid and not subject to IMR. If a treatment request is denied without medical review, there is no UR decision to appeal to IMR. The WCAB concluded that legal issues regarding the timeliness of a UR decision must be resolved by the WCAB not IMR.

The WCAB concluded that IMR physicians only resolve medical necessity disputes.

The WCAB stated that there is no question that 4610 and 4610.5 provide that disputes over UR decision shall be resolved by IMR. Section 4610 (g) (3) (A) states that if a UR decision does not fully approve a treatment request, the dispute shall be resolved pursuant to section 4610.5, if applicable. The WCAB further pointed out that various provisions of unqualified section 1 of SB 863 expressly declare a legislative intent that IMR is to be the vehicle for reviewing a UR decision.

The Board went on to state, however Labor Code §§ 4610.5 and 4610.6 expressly circumscribe the role of an IMR physician to evaluate the medical necessity of the proposed treatment. Section 4610.6 (a) states that IMR shall be limited to an examination of the medical necessity of the disputed medical treatment. These provisions of section 4610.5 and 4610.6 are consistent with the unqualified section 1 of SB 863, which declares a legislative intent that having medical professionals ultimately determine the necessity of requested treatment furthers the social policy of this state.

Nothing in SB 863 suggests the IMR physicians will have either the legal expertise or resources to decide whether a UR decision was untimely. To the contrary, SB 863 consistently refers to the IMR physicians as medical professionals. Additionally, although section 4610.5 specifies what documents are provided to the IMR organization, Labor Code § 4610.5 nowhere indicates that IMR physicians are to be provided with documentation relating to the timeliness of defendant's UR decision or with legal authority relating to the timeliness of UR.

Accordingly the WCAB found that UR timeliness are not issues of medical necessity and cannot be resolved by IMR.

The timeliness of a UR decision is a legal dispute within the jurisdiction of the WCAB. Legal disputes over UR timeliness must be resolved by the WCAB as the WCAB has exclusive jurisdiction over claims for recovery of compensation, or concerning any worker liability arising out of or incidental thereto. Labor Code §§ 4610.5 and 4610.6 limits IMR to disputes over medical necessity.

All other disputes regarding a UR decision must be resolved by IMR.

In addition to timeliness, UR decision must be in compliance with other elements of section 4610. With the exception of timeliness all other requirements go to the validity of the medical

decision or decision-making process. The sufficiency of medical records provided, expertise of the reviewing physician and compliance with MTUS are all questions for the medical professional.

If an injured worker disputes a UR decision, section 4610 mandates that it shall be resolved in accordance with section 4610.5 if applicable. Similarly, sections 4610.5 and 4610.6, specifically provides that where there is a dispute regarding a UR decision on medical necessity the dispute shall be resolved only by IMR. With the exception of timeliness, all defects and UR process can be remedied when appealed to IMR.

The legislator has made it abundantly clear that medical decisions are to be made by medical professionals. To allow a WCJ to invalidate a UR decision based on any factor other than timeliness and substitute his or her own decision on a treatment request violates the intent of SB 863. The WCAB reasoned that the legislative intent is clear. IMRs sole mechanism for reviewing a UR physician's opinion regarding the medical necessity of the proposed treatment.

The WCAB held that where a UR decision is timely, IMR is the sole vehicle for reviewing the UR decisions expert opinion regarding medical necessity of a proposed treatment, even if the UR process does not fully comply with section 4610 requirements.

The WCAB stated that there holding does not imply that UR is not important nor the compliance with section 4610 is unnecessary. UR is a critical part of the medical treatment review process. If done properly, UR is effective, expeditious and inexpensive.

Although the failure to comply with the requirements of 4610 will not invalidate a UR decision it can result in: (1) the assessment of significant monetary penalties by the AD; (2) increase compensation to the injured worker under section 5814 for an unreasonable delay in completing UR. All requirements of section 4610 should be complied with; however, failure to do so will not invalidate a UR decision. A defective UR can be corrected by exercising an internal UR appeal process, if applicable, or through IMR were both parties may submit records, and for which an appeal process has been established.

Timeliness, however, cannot be fixed. Whether a UR decision is timely is a legal determination and must be decided by a WCJ. An untimely UR decision is the same as no UR. Without a UR decision, there is nothing to appeal to IMR.

If the UR is untimely the WCJ can only award treatment if there is substantial evidence supporting the legal necessity of the treatment requests.

If the UR decision is untimely, the injured employee is nevertheless entitled only to reasonably required medical treatment and it is the employee's burden to establish his or her entitlement to any particularly treatment, including showing either that the treatment falls within the

presumptively correct MTUS or that the presumption has been rebutted. Moreover, to carry this burden, the employee must present substantial medical evidence.

The WCAB concluded the issue of the need for surgery was not moot. The WCAB ordered their decision after reconsideration rescinded, the petition for recon filed by applicant was denied and the findings and order of the WCJ is affirmed.

One Commissioner wrote a concurring opinion. The concurring Commissioner agreed with the majority's holding regarding the merits of the case. However the Commissioner did not think it was necessary to reach the merits. She would have dismissed the defendant's petition for reconsideration and applicant's additional petition for reconsideration and vacate the first Dubon decision as the need for surgery was moot. The concurring Commissioner stated that even assuming the issue of applicant's entitlement to surgery was not moot when they issued the first decision, it has since become moot because the issue went to IMR (which is where it properly belongs) and the applicant is now filed a petition with the WCAB appealing the IMR determination.

Although the concurring Commissioner unequivocally agrees with the majority's holding, she maintains that it was not necessary to reach the merits in this case.

A second Commissioner issued a concurring and dissenting opinion. This Commissioner agreed that an untimely medical determination is not subject to independent medical review. This Commissioner agreed that the decision in Dubon I was correct.

10. Medical Treatment

Jennifer Patterson v. The Oaks Farm (SPD) 79 C.C.C. 910

Applicant admittedly sustained serious industrial injury to her head, neck, lumbar spine, psyche, and in the form of headaches on May 6, 1999, when the horse she was training tripped. Her back injury was treated by surgery in 2008, but she continued to experience symptoms of pain along with headaches and neck pain. The pain and headaches were treated with numerous medications, and applicant utilized the services of more than one physician. Nurse case manager services were authorized and provided by defendant, but were later unilaterally terminated by defendant.

An expedited hearing was thereafter held on January 28, 2014.

The issues addressed at the January 28, 2014 expedited hearing are identified in the Minutes of Hearing as follows: "1. whether there was good cause to discontinue the services of a nurse case manager by defendant. 2. Whether there is good cause to order reinstatement of nurse case management services as requested by applicant. 3. Whether reinstatement of a nurse case manager requires a request for authorization for treatment. 4. Whether nurse case management services qualify as treatment for purposes of an expedited hearing under Labor Code Section

4600.” The WCJ found that there was no good cause to discontinue services, a nurse case manager was reasonable for this case, a Request for Authorization was not required, and a request for a nurse case manager is deemed medical treatment. A petition for reconsideration was filed and the board issued a significant panel decision.

The WCAB held that the provision of a nurse case manager is a form of medical treatment under Labor Code Section 4600. They determined that the coverage of section 4600 extends to any medically related services that are reasonably required to cure or relieve the effects of the industrial injury, even if those services are not specifically enumerated in that section. The description of required medical treatment in section 4600 expressly includes “nursing” services, which encompasses the services of a nurse case manager, as well as practical nursing services performed by unlicensed persons.

The WCAB’s second holding: “An employer may not unilaterally cease to provide approved nurse case manager services when there is no evidence of a change in the employee’s circumstances or condition showing that the services are no longer reasonably required to cure or relieve the injured worker from the effects of the industrial injury.” Unilaterally terminating medical treatment that was earlier authorized as reasonably required to cure or relieve the injured worker from the effects of the industrial injury is contrary to section 4600(a) unless supported by substantial medical evidence. They argue that a subjectively belief that applicant was difficult to deal with was not substantial evidence in which is a basis to terminate medical treatment. When defendant initially provided nurse case manager services it effectively acknowledged that the services were reasonably required to cure or relieve the effects of the industrial injury in this case. It is defendant’s burden of proof to show that they are no longer needed. Defendant was required to meet that burden through the presentation of substantial medical evidence. However, defendant did not do that at the January 28, 2014 expedited hearing.

The board further held that use of an Expedited Hearing to address the medical treatment issue in this case is expressly authorized by Labor Code Section 5502(b)(1), and lastly that it is not necessary for an injured worker to obtain a request for authorization to challenge the unilateral termination of the services of a nurse case manager.

The board argued that Defendant acknowledged the reasonableness and necessity of nurse case manager service when it first authorized them, and applicant does not have the burden of proving their ongoing reasonableness and necessity. Rather, it is defendant’s burden to show that the continued provision of the services is no longer reasonably required because of a change in applicant’s condition or circumstances. Defendant cannot shift its burden onto applicant by requiring a new Request for Authorization and starting the process over again.

It is defendant’s burden to show a change in applicant’s condition or circumstances. Defendant, in this case, did not present any evidence that a nurse case manager is not reasonable medical

treatment in this case. Applicant has no obligation to continually show that the use of a nurse case manager is reasonable medical treatment. Defendant failed to meet its burden of showing by substantial evidence that applicant's condition and circumstances changed in a way that made the further provision of nurse case manager services no longer reasonable medical treatment in this case.

The Judge's decision was affirmed.

11. Verification

Christopher Torres v. Contra Costa Schools Insurance Group (SPD) 79 C.C.C. 1181

Applicant sustained an admitted injury to his left knee on 10/15/98 and on 7/28/00 to his neck and spine causing 27% P.D. and need for future medical care. Applicant's treating doctor, Dr. Grant, requested a refill of Duragesic patches and Norco in June 2013. The UR doctor issued a determination July 9, 2013 certifying the request for Norco but conditionally denying the patches. In that denial the UR doctor wrote that the denial was based on the fact that requested information had not been received but the request would be reconsidered when the information was received. Applicant disagreed with the UR determination and submitted an application for IMR on 8/2/2013. On 11/12/2013 an IMR determination was issued stating that the Duragesic patches were not medically necessary. On 12/18/2013 the applicant's attorney filed an appeal of the IMR determination. The IMR appeal was signed but not verified. Applicant also filed a D.O.R. for expedited hearing on the issue of medical treatment. The expedited hearing was heard on 1/9/2014. The Judge thereafter issued an opinion dismissing the IMR appeal for lack of verification.

Applicant files for reconsideration. In the decision the board reiterates Rule 10450(e) which states that an unverified petition filed with the WCAB may be summarily dismissed. They also reiterate L.C. 4610.6(h) which allows for a "verified appeal from the medical review of the determination of the administrative director". The board states that a lack of verification does not necessitate automatic dismissal of a nonconforming pleading. However, failure to correct a lack of verification within a reasonable time after receiving notice of the defect would allow for dismissal of the nonconforming petition.

In this case defendant raised the issue but applicant did not seek to correct the defect. The board, however, recognized that the verification requirement of 4610.6(h) is relatively new and that there is a strong public policy in favoring disposition of cases on their merits. Therefore, the board rescinded the dismissal of the IMR appeal for the lack of verification and returned it to the Judge. Applicant was given 20 days after service of the decision to file the verification or amend the appeal. IF the appeal does so the WCJ is to address the merits. If the applicant fails to correct the defect within 20 days the WCJ may dismiss for lack of verification.

12. Utilization Review

Bodam v. San Bernardino County (SPD) 79 C.C.C. ____

The WCJ found that the WCAB had jurisdiction to adjudicate when utilization review is untimely and that defendant's UR of the Request for Authorization (RFA) to perform spinal surgery submitted by one of the applicant's physicians, Wayne Cheng M.D., was untimely and lacked the necessary signature. The WCJ further found that the record did not include substantial evidence to allow proper determination of the treatment request, and for that reason ordered the record reopen for development by submission of a supplemental report from Dr. Cheng concerning the proposed surgery.

Defendants contend the WCAB has no jurisdiction to adjudicate the validity of the UR, that the UR was timely conducted and that the lack of a signature and its transmittal one day after the time allowed by the rules of the A/D does not make the UR invalid and that the WCJ issued inconsistent findings that do not support his decision.

The WCAB held as follows:

1. a defendant is obligated to comply with all time requirements in conducting UR, including the time frames for communicating the UR decision;
2. a UR decision that is timely made but is not timely communicated is untimely;
3. when a UR decision is untimely and, therefore, invalid, the necessity of the medical treatment at issue may be determined by the WCAB based upon substantial evidence.

In this case the board held that the WCJ correctly determined that defendants UR decision was not timely communicated and therefore invalid. Further, the WCJ properly ordered further development of the record by directing the parties to obtain a supplemental report from Dr. Cheng and therefore removal was denied.

The WCAB held the time limits in LC 4610 are mandatory including both the time limits within which a UR decision must be made as well as the time limits in which it must be communicated.

The WCAB citing to Dubon II indicated the WCAB held that the WCAB has jurisdiction to determine whether a UR decision is timely. If the UR decision is found untimely, the UR decision is invalid. If the UR decision is found untimely the WCAB must decide the issue of medical necessity of the requested treatment based on substantial medical evidence. The employee bears the burden of proving the treatment is reasonably required.

Labor Code section 4610 (g) (1) provides that decision shall be made in a timely fashion that is appropriate for the nature the employee's condition, not to exceed five working days from the

receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

In the present case the board stated the RFA was received on October 28 and the UR decision was timely made three days later on October 31, 2013. However, the board stated a UR decision not only must be timely made; it must be timely communicated. A UR decision that is not timely communicated is of no use and defeats the legislative intent of the UR process that balances the interests of speed and accuracy, emphasizing the quick resolution of treatment requests. Therefore section 4610 (g) (3) (A) imposes further mandatory time requirements for communicating a UR decision. These time limits run from the date the UR decision is made, even if the UR decision is made in less than the five days allowed under LC 4610 (g) (1) which provides decisions to approve, modify, delay, or deny request by physicians for authorization shall be communicated to the requesting physician within 24 hours of the decisions. Decisions resulting in modification, delay or denial of all or part of the requested treatment shall be communicated to the physician initially by telephone or fax, and to the physician and the employee in writing within 24 hours for concurrent review, or within two business days of the decision for perspective review, as prescribed by the ADA.

Section 4610 (g) (3) (A) was clarified by former rule 97 92.9.1 (e) (3), which, at the time of the defendants UR determination provided that a decision to modify, delay, deny shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, fax or e- mail. The communication by telephone shall be followed by written notice to the requesting physician within two business days for perspective review.

In this case there is no evidence that defendant or its UR provider phoned, faxed, or E-mailed to Dr. Cheng within 24 hours after defendant made its UR decision on October 31, 2013. Therefore, defendants UR decision is untimely and invalid for that reason.

Additionally the board held that defendants UR decision is untimely because written notice was not sent to Dr. Cheng, applicant and applicant's attorney within two business days after the UR decision was made. The only evidence a written communication of UR decision is the two denial letters, which are dated November 5, 2013. This is beyond the statutorily required two business days after the Thursday, October 31, 2013 decision was made.

The WCAB found the WCJ was correct in finding the UR untimely and therefore removal was denied.

The board went on to state that once UR is untimely the WCAB has authority to determine the issue of medical necessity. However, decision regarding medical necessity of treatment must be supported by substantial evidence in light of the entire record.

The WCJ concluded in this case that neither party presented substantial evidence that would support a decision concerning the proposed surgery. When neither party has presented substantial evidence, the WCJ may order development of the record. The WCJ properly concluded there is a need to develop the record by obtaining a supplemental report from the physician requesting the surgery.

Defendant's petition for removal was denied.

DENIALS OF WRITS OF REVIEW

13. MPN

San Diego Unified School District v. W.C.A.B. (Robledo)(W/D)79 C.C.C. 95

Applicant suffered injury to her knees, ankle and hip on 4/29/2010. Defendant had a validly established MPN. Applicant received treatment through the MPN including surgery. Applicant became unhappy with the MPN doctor and after moving from San Diego to Riverside began treating with a non-MPN doctor.

The matter proceeded to trial on the issue of MPN and medical treatment. After trial the Judge found that the defendant did not provide adequate notice to the applicant regarding the MPN and therefore there was a "denial of care". Applicant was awarded the cost of treatment outside of the MPN. Defendant filed a petition for reconsideration alleging that the defective notices did not result in a denial of care which was required for defendant to be liable for treatment outside of the MPN.

The WCJ in her report explained that she used a two-prong analysis. 1) Whether there was a failure by defendant to provide adequate notice; and if so 2) whether the failure to give notice resulted in a denial of medical care.

Applicant testified that she did not remember receiving any notices about what to do about an industrial injury and did not see any notices posted in the workplace. She did not know she had a choice to change doctors when she became unhappy with the MPN doctor. Applicant obtained an MRI outside of the MPN and it was only after showing the MPN doctor the MRI that she was finally able to obtain surgery.

The WCJ was of the opinion that the applicant was not informed of her rights to change treating doctors until much later on in her treatment. The rules require that the applicant be given notice that she has the right to a free choice within the MPN after the initial 30 day period following the

injury. This was not done. And even when it was done, the notices were sent to her attorney and were not in compliance with statutory or regulatory notice requirements.

The WCJ found that inadequate notice did not by itself authorize treatment outside of the MPN. The WCJ stated that she found that the defective notices resulted in a denial of treatment because they deprived applicant of knowledge regarding how to dispute the finding of her treating MPN physician and to find another provider in the network. It was only after the applicant obtained an attorney that she was able to obtain a list of doctors after most of the treatment was already provided.

Further the judge found that defendant had multiple opportunities to correct the defective notices but failed to do so.

The WCAB denied reconsideration. Defendants filed a petition for writ of review which was also denied.

14. Evidence

NBC Universal Media v. W.C.A.B. (Moussa)(W/D) 79 C.C.C. 191

Applicant sustained injury to her knees, low back and psyche on 2/19/2002, 4/18/2008 and a cumulative trauma. At trial applicant relied on the treater, Dr. Greenspan who found 12 WPI to the lumbar spine, 16% to the right knee and 8% to the left knee. He apportioned 20% to non-industrial for the lumbar spine.

Dr. Hay the PQME found 29% WPI to the lumbar spine 8% to the thoracic spine and 10% to the right knee and 12% to the left knee. Apportionment was 50/50 between industrial and non-industrial for the lumbar spine. He apportioned 50% to non-industrial causation for the knees.

At trial the Judge issued an FA&O finding applicant sustained 71% disability based on Dr. Greenspan's PD finding as to the knee disability and apportionment and Dr. Hay's finding on the spine. The Judge determined that the apportionment determined by Dr. Hay was not substantial evidence.

Defendant filed a petition for reconsideration. The WCJ recommended that recon be denied. The Judge explained that he used the "range of evidence". He argued that there were serious deficiencies in both doctors' reports which were cured by reference to the other. He was of the opinion that the doctor's did a good job with some of the explanation of the impairment and a poor job with other parts. The Judge explained that by using the "range of evidence" he could craft a complete picture and obviate the time-consuming task of developing the record.

The WCAB denied reconsideration. Defendant filed a petition for writ of review which was also denied.

15. Apportionment

New Axia Holdings v. WCAB (Martinez) (W/D) 79 C.C.C. 196

Applicant sustained injury on 12/4/2002 to his lumbar spine. He had a prior injury on 12/3/90 with another employer to his back and lower extremities in which he received a stipulated award of 28% PD. In the 1990 stip and award the award stated that applicant “sustained injury aoe/coe to his back and lower extremities as described in the medical file herein”. There was no attached medical file. The only evidence of the prior injury was in the stip and award.

The matter proceeded to trial and the WCJ determined that the applicant sustained a 17%, after she subtracted 28% PD from the current PD under L.C. Section 4664.

Applicant filed for reconsideration arguing that the apportionment was not correct and that the WCJ erred in the rating of the PD of 40 standard since this did not take into account all of the work restrictions provided by Dr. Lipton. The WCJ recommended that reconsideration be denied. The WCJ stated that although the existence of prior PD is rebuttable it is the applicant’s burden to prove that the prior disability no longer exists. It was the WCJ’s opinion that she had no choice but to subtract the prior 28% PD from the award she issued. The WCJ also stated that she used a range of evidence to determine the work restrictions.

The WCAB granted reconsideration and in a split panel decision determined that although an award of prior PD conclusively presumed that the prior PD still existed it is still the defendant’s burden to prove overlap between an applicant’s current PD and prior award establishing its right to apportionment. (Citing *Kopping*) Pursuant to *Kopping* the burden of proving overlap is part of the employer’s overall burden of proving apportionment. Defendant must prove an overlap of the disability that defendant seeks to subtract from the PD award. The WCAB also explained that it is not the applicant’s burden to prove rehabilitation from a prior injury.

The WCAB found that the record was insufficient to make a determination with respect to overlap under L.C. 4664, and therefore the WCAB found no basis for subtracting the 28% from the award.

Further the WCAB found that the Judge should have taken into consideration the additional factors of disability in Dr. Lipton’s latter reports. The matter was returned to the trial level for the WCJ to submit the report to the DEU for formal rating. Defendant filed a petition for writ of review which was denied.

16. Interest

Monterey County Superior Court v. WCAB(Martinelli) (W/D) 79 C.C.C. 1082

Applicant sustained an admitted injury while working as a Deputy Court Clerk. The case was resolved via C&R for \$10,000 less PDAs and attorney's fees. The net balance to applicant was \$4,360. On 9/11/2012 defendant sent a check to applicant in the amount owed. Defendant also mailed a check to applicant's attorney per the C&R. The attorney received the check. Applicant claimed she did not. Defendant sent a second check on 1/13/2013 in the same amount. No interest was included. Applicant sought penalties for unreasonable delay. The matter proceeded to trial. The Judge issued an F&A and a N.O.I. finding that defendant had not unreasonably delayed payment of the award but had unreasonably delayed payment of the interest in the amount of \$121.20 but had done so by inadvertence. The WCJ gave notice that he intended to impose a penalty in the amount of \$12.12. Defendant objected and filed for reconsideration.

On reconsideration defendant argued that they did not owe interest to applicant since they did not delay payment and mailed a check to applicant at the correct address. The C&R provided that if payment was made within 30 days no interest would be due. The WCJ recommended that reconsideration be denied stating that L.C. Section 5800 indicates that all awards carried interest on all due and unpaid payments from the date of the making and filing of the award. Further stating that until delivery of the check occurred the issuance of the check does not discharge the underlying obligation pursuant to U.C.C. Section 3420. Until the check was both issued and paid the interest continues to run. In accordance with the C&R and L.C. Section 5800 interest of \$121.20 was due on the award. The WCAB denied and incorporated the WCJ's report. Defendant filed a petition for writ of review, which was denied.

17. Interpreters

Solano v. W.C.A.B. (W/D) 79 C.C.C. 1092

Applicant claimed to have sustained an injury on 10/13/2011 while working as a laborer. Defendant scheduled the applicant's deposition. Applicant's attorney requested to arrange for the Spanish speaking interpreter. Defendant denied the request and applicant filed a petition for a protective order asking the WCAB to allow applicant to select his own interpreter. The matter proceeded to hearing with defendant arguing that they had the right to appoint the interpreter for the deposition. The WCJ issued an order denying applicant's petition. In denying the petition the WCJ relied on L.C. Section 5811 and the holding in Contreras v. Gibson Farms finding that it is the party that notices the deposition or produces the witness that is entitled to select the interpreter. Section 5811(b) provides that the party "producing the witness" must select and provide for the interpreter. Where defendant notices applicant's deposition the plain meaning of "producing party" in 5811 confers upon defendant the duty to select and provide for the interpreter. Applicant filed for removal arguing that the WCJ's interpretation of the term

“producing the witness” as used in 5811 was contrary to decades of published case law and that the party producing the witness is the party for whose benefit it is expected that the witness will testify. And that the order was inconsistent with provisions of the C.C.P. that contemplate that the deponent is the producing party. The WCJ recommended removal be denied.

In the WCJ’s report he cited several cases involving L.C. Section 5710 disputes that illustrate that the C.C.P. discovery statutes generally do not apply in workers’ compensation cases. The Judge further cited 5811(b) finding that defendant has the duty to select the interpreter. The WCJ addressed applicant’s contention that having to utilize an interpreter provided by defendant would violate attorney-client privileged communications. The WCJ pointed out that all interpreters must be qualified by way of certification, and that certified interpreters may not disclose confidential information. Any attempt by a party to obtain confidential information is construed as a bad faith tactic and is subject to L.C. Section 5813 sanctions. The WCAB adopted and incorporated the WCJ’s report. Defendant’s petition for writ of review was denied.

18. Discovery and Protective Orders

County of San Bernardino v. W.C.A.B (Foroughi) (W/D) 79 C.C.C. 1200

Applicant sustained injury from 7/1/2008 through 8/9/2013 due to psyche. Applicant alleged that during her 25 year employment with the defendant she sustained psychiatric injury due to treatment by her supervisor, Axel Colin. Defendant denied the claim.

At deposition Mr. Colin appeared as the employer representative. Applicant began crying uncontrollably and was in severe distress. The deposition was terminated and applicant filed a petition seeking a protective order that would bar the appearance of Mr. Colin and Ben Mentijo, Mr. Colin’s supervisor. Applicant also filed a medical report supporting the petition.

Defendant filed a petition to compel arguing that defendant had every right to have a rep at the deposition and the WCAB could not limit the identity of that rep. The WCJ issued an order compelling applicant to attend. Applicant filed a petition for removal asking the WCAB to rescind the order and issue a protective order. Applicant argued that under C.C.P. Sections 2016.040 and 2025.420 the courts may issue orders to protect persons from “unwarranted annoyance, embarrassment, or oppression or undue burden and expense”. Also that Mr. Colin was not a party to the case and did not have a right to be present. The WCJ recommended that removal be denied.

The WCAB granted removal, rescinded the order and issued a protective order barring Mr. Colin from the deposition. The WCAB determined that the medical report as well as applicant’s unrebutted statement that she had uncontrollable shaking and crying when in Mr. Colin’s presence was sufficient to demonstrate that his presence at the deposition would result in oppression within the meaning of C.C.P. 2025.420. They found that exclusion of Colin does not

prevent defendant from designating another rep. The WCAB acknowledged that the medical report supporting applicant's argument was not substantial evidence but sufficient to exclude the supervisor from the depo. Defendant filed a petition for writ of review which was denied.

19. Vocational Experts

Fetner v. City of Long Beach (W/D) 79 C.C.C. 1204

Applicant worked as a firefighter from 1982 through 2007. He filed an application on 5/12/2009. Thereafter applicant obtained a vocational expert pursuant to Ogilvie to address issues regarding the DFEC. Defendant sought to have applicant evaluation by their vocational expert. Applicant's attorney would not make applicant available unless defendant followed the procedures set forth for a deposition in L.C. Section 5710 including payment of applicant's attorney's fees for the attorney's presence. Defendant would not agree and the matter proceeded to trial. The WCJ issued an opinion finding that defendant was entitled to have their vocational expert evaluate applicant without using the L.C. Section 5710 procedures. The WCJ reasoned that there is no statutory mandate requiring use of L.C. Section 5710 procedures to obtain a vocational expert interview. The WCJ pointed out the language in 5710 "...the appeals board, a workers' compensation Judge or any party to the action or proceeding, may cause the deposition of witnesses..." Since the vocational expert is not a party the WCJ concluded that the expert would have no authority under 5710 to cause the deposition of a witness. Applicant filed for reconsideration.

In applicant's petition applicant argued that the decision would require applicant to submit to questioning by an expert without the permission of his attorney and the order violates the Rules of Professional Conduct because it allows indirect communication by defendant with the injured worker and potentially violates the applicant's right to privacy. Applicant argued that the use of L.C. 5710 procedures in the situation is consistent with the established methods of discovery.

In the WCJ's report he pointed out that 5710 not only limits who may cause the deposition of a witness but it is specifically silent regarding extending its parameters to other discovery. He found that there was no authority to extend the provisions of 5710 to the vocational expert interviews. Indicating that defendant may have its expert interview applicant without the use of the L.C. Section 5710 procedures. The WCAB denied reconsideration. Defendant's petition for writ of review was also denied.

20. Apportionment

Morris v. W.C.A.B. (W/D) 79 C.C.C. 1348

Applicant suffered 3 injuries while working as an RN. Applicant stopped working in 11/2004. She was evaluated by three AMEs in different specialties. All three AME reports were

submitted at trial and indicated that applicant was PTD from her injuries. Applicant argued that she was entitled to an unapportioned award of 100% “in accordance with the fact” under L.C. 4662, based solely on the 9/10/2004 injury since this injury alone caused 100% disability. The WCJ issued three separate F&As finding applicant 90% disabled due to the 9/10/2004 specific, 23% due to the CT and 6% due to the 5/11/2004 injury. Applicant sought reconsideration arguing that the medical evidence supported 100% PTD on the basis of the 9/10/2004 injury alone and this injury caused an inability to compete in the open labor market.

The WCJ recommended that reconsideration be denied. The WCJ stated that applicant failed to present vocational expert testimony to support that she was unable to compete in the open labor market. That the AME stating applicant could not compete in the open labor market was insufficient, and that the doctor’s apportioned the disability, which must be taken into account even when an applicant is deemed PTD “in accordance with the fact” under L.C. 4662. The WCJ argued that even though the AMEs found she was unable to compete in the open labor market these doctors also found apportionment to non-industrial factors. Applicant did not present sufficient evidence to rebut the scheduled PD rating for her 9/10/2004 injury nor did she establish that the AME’s apportionment of her PTD was inconsistent with the apportionment to causation.

The WCAB, in a split panel decision denied reconsideration and adopted and incorporated the Judge’s decision. One Commissioner dissented stated that she would have granted recon and return the matter to the trial level for development of the record. In the dissented it was pointed out that two AMEs determined that the applicant could not compete in the open labor market due to her failed cervical surgeries necessitated by the 9/10/2004 injury. The psych AME testified that applicant had no psyche disability in the year prior to her 9/10/2004 injury and now due to her psyche disability could not manage gainful employment. The Commissioner also disagreed with the Judge that a physician’s determination that an injured worker is not able to compete in the open labor market is inadequate rebuttal evidence.

The applicant’s writ was denied.

REPORTED WCAB AND PANEL DECISIONS

21. Medical Treatment

Castro v. U.S. Fire Ins. (BPD) 42 CWCR 200

Applicant injured his back and defendants accepted liability for the injury and provided benefits. The parties agreed to an Agreed Medical Evaluator. The Agreed Medical Evaluator as part of his report indicated the applicant was in need of home care four hours each day seven days a week along with transportation to and from medical appointments.

At a hearing on October 10, 2013 defendant stipulated to authorize transportation and home care services per the report of the Agreed Medical Evaluator. The WCJ Incorporated the stipulation into the minutes and it became final.

Despite the stipulation and order defendant failed to provide home care transportation services the applicant requested an expedited hearing. At the expedited hearing the applicant offered no evidence. The WCJ awarded the transportation and home care. Defendants filed a petition for reconsideration.

The WCAB agreed with the WCJ. The WCAB concluded that when defendant stipulated to authorize the services for the home care and transportation they acknowledge the home care and transportation services were reasonable medical treatment. The defendant having agreed to authorize the treatment became obligated to continue providing treatment until it was no longer reasonably required.

WCAB indicated as in the case with other medical treatment issues, a determination that medical treatment is no longer required must be based on substantial medical evidence. The WCAB reasoned that there was no need for applicant to present evidence supporting the continued need for services at the expedited hearing because it was the obligation of the defendant if they wanted to justify no longer furnishing such treatment to show that it was no longer required because of the change in circumstances. Defendants failed to introduce such evidence and therefore did not meet their burden of proof nor did the burden of proof shift to the applicant to show a continuing need.

WCAB admonish that a defendant may not unilaterally disregard stipulation for board orders, but it must seek relief from them by showing good cause. In the present case the WCAB observed defendant had not offered any evidence that the home care and transportation services recommended by the Agreed Medical Evaluator were no longer required. All the evidence in the record justified the provision of the home care and transportation services to which defendant had previously stipulated in which the WCAB ordered. The WCAB affirmed the WCJ's decision.

22. 104 -Week Cap

Villalobos v. Bright Horizons Family Solutions(BPD) 42 CWCR 68; ADJ 8451897

The applicant sustained an admitted injury to her ankle on 6/24/2011. The matter proceeded to expedited hearing on 10/8/2013 on the issue of temporary disability. The parties stipulated that applicant had been paid temporary total disability for 44 weeks and had been paid temporary partial disability for 60 weeks. The matter was submitted solely on the issue: Does Labor Code Section 4656 limit payment of TDI to 104 compensable weeks apply to both TDI and TPDI or

does it only apply to TDI? The WCJ determined that the 104 week cap applied only to payments of TDI and not TPDI and awarded additional weeks of TDI. Defendant filed for reconsideration.

The board reiterated the text of Labor Code 4656 and finding that it was clear on its face. By its plain and express terms 4656 establishes a limit of 104 weeks within a period of five years for “aggregate disability payments”. It does not distinguish between TTD and TPD, it applies equally to both. They found that 4656 imposes a 104 week cap on all TDI unless certain exceptions apply. The construction determined by the board is consistent with the en banc decision in *Hawkins v. Amberwood Products (2007)* holding that the limitation of 104 compensable weeks within two years begins on the date TDI is first paid without distinguishing between partial or total disability indemnity.

The defendant was found obligated to pay 104 weeks of TDI and since that had already been done no further TD was owed.

The WCJ’s determination was rescinded.

23. AOE/COE

Evans v. San Joaquin Regional Transit District (BPD) 42 CWCR 69

Applicant claimed a CT injury to the spine while working as a bus driver. The applicant claimed a further injury caused by a rear-and collision while she was traveling to the office of an AME for evaluation. Both claims were disputed.

The AME issued eight reports with varying conclusions as to whether there was a CT injury. In the final report he recognized the confusion that had been generated and came to an ultimate opinion that there was no CT injury.

The WCJ found both claims compensable and awarded 15% PD in the CT injury and 14% for the auto accident on the way to the AME exam.

Defendants filed a petition for reconsideration.

The WCAB granted reconsideration.

As to the CT injury the panel reasoned that the AME had wavered repeatedly on the issue of causation but in the end concluded there was no such trauma. The WCAB indicated the WCJ had selectively considered a medical report incapable of meeting applicant’s burden of proof required to establish compensability.

As to the auto accident the panel concluded that was not compensable because the accident could not have been a compensable consequence of an underlying injury, since there was none. (*Southern Calif. Rapid Transit District v. WCAB (Weitzman)* 44 CCC 107)

A compensable consequence must be causally related to an initial industrial injury.

The WCAB stated there are two reasons to find the accident was not a compensable injury: first, there was no underlying industrial injury; second applicant was not traveling to or from a medical treatment appointment, but rather traveling to obtain medical-legal evidence regarding her claim. It was thus part of the litigation process and did not arise out of and occur in the course of employment. (*Rodriguez v. WCAB 59 CCC 14*)

The WCAB granted recon and issued a take nothing decision in both cases.

24. Liens

Rodriguez v. Zenith (BPD) 42 CWCR 45

The case summarized below reverses prior panel decisions had held that physicians could bill their usual and customary fee in cases where injury was denied and ultimately injury was found and the treatment was found to be reasonable and necessary. This case eliminated the injury denied exception to applying the OMFS.

The board indicated laws have changed and the physicians are bound by the OMFS, unless they come under the circumstances set forth in A.D. rule 9792 (c).

Applicant suffered a hernia in the course of employment. The hernia was repaired at Kaiser Foundation Hospital. Defendant denied liability for the injury. Kaiser filed a lien for \$7019.65 for its services.

Applicant's claim went to trial and the WCJ found the applicant sustained an injury. Further hearings were held at which the issues were framed as to temporary disability, permanent disability, need for treatment and the liens of Kaiser and EDD.

Defendant introduced evidence that Kaiser had been paid some funds. Kaiser produced records showing a balance of \$3050.52.

The WCJ following the hearing allowed Kaiser's lien in full. The WCJ found that the Kaiser physician was the PTP. In addition the applicant was awarded permanent disability, action on the EDD lien was deferred and the applicant was awarded further medical treatment.

Defendant filed a petition for reconsideration. Defendant argued that Kaiser should have been limited to the Official Medical Fee Schedule (OMFS). In addition defendant's raised the issue of the applicant's earnings and the Judge deferring the EDD lien.

The WCJ recommended the WCAB correct his findings on earnings and defer the payment of PD pending resolution of the EDD lien. The WCAB limited Kaiser to the OMFS. The WCAB found Kaiser to be the PTP, corrected the earnings and deferred PD and the EDD lien.

The majority began by pointing out that several writ denied cases including (*Valdez*) (62 CCC 1145), have held that medical providers were not limited to the OMFS amounts when the injured employees claim was denied. The WCAB pointed out they are not bound by panel decisions.

The WCAB further indicated the statutory basis for those prior decisions had changed. The minimum fee schedule in existence in 1973 was subsequently replaced by the OMFS, which establishes a reasonable maximum fee. (LC 5307.1)

The circumstances under which a medical provider may recover more than the OMFS are set forth in A.D. rule 9792 (c) as follows:

A medical provider or a license healthcare facility may be paid a fee in excess of the reasonable maximum fees if the fee is reasonable, accompanied by itemization, and justify by explanation of the extraordinary circumstances related to the unusual nature of the services rendered; however, no event shall the physician charging excess of his or her usual fee.

At the time the *Valdez* case was decided defendant had the burden of proving that a treating physician charges were excessive, but now lien claimants have that burden of proving that their charges are reasonable. (*Tapia*, WCAB en banc, 73 CCC 1138)

Reviewing the record before it the majority observed that Kaiser had not presented any evidence justifying charges in excess of those provided in the OMFS.

In response to defendant's argument that the Kaiser physician could not be applicant's primary treating physician because he was not a member of defendant's MPN, the majority wrote there was nothing in the record indicating that defendant ever acted to transfer applicant's treatment into its MPN.

A dissenting Commissioner would have allowed Kaiser the full recovery and customary charges. He reasoned that *Valdez* was still good law.

25. Presumption of Compensability

Avila v. Associated Pacific Construction (BPD) 2014 Cal. Wrk Comp. P.D. LEXIS 185

The WCAB held that applicant who claimed an injury to his respiratory system was not presumed compensable because there was no evidence the applicant filed a claim form with the employer as required by LC § 5401 (c) and (d).

The WCAB found that to trigger the LC § 5402 (b) presumption of compensability the use of a claim form is mandatory and the filing of the application for adjudication of claim is not sufficient to trigger the presumption.

The applicant was allowed to amend his pretrial conference statement on day of trial to include respiratory system as an injured body part in addition to right leg injury already listed on pretrial conference statement.

The WCAB stated that when defendant filed the declaration of readiness to proceed requesting an AOE-COE trial without limitations, applicant's application for adjudication of claim listed body parts injured his right leg, back, bilateral wrist, foot common respiratory system, thereby providing defendant with notice that other body parts including respiratory system were in dispute. Further, applicant listed 40 medical reports from several doctors who treated the applicant for injury to body parts other than his right leg all without objection from defendant. Therefore, the WCAB found that defendant knew or should have known that applicant was actively litigating all body parts.

26. Substantial Evidence

Gomez v. County of Los Angeles (BPD) 2014 Cal. Wrk. Comp. P.D. LEXIS 119

The WCJ found the applicant 100% totally disabled with no apportionment as a result of an October 5, 2000 injury.

The WCAB rescinded the WCJ's finding and referred the matter back to the trial level to further develop the record.

The WCAB found that the report of the agreed medical examiner upon which the WCJ relied indicating the applicant was unable to compete in the open labor market, did not constitute substantial evidence to support the WCJ's finding of permanent total disability because the agreed medical examiner was not a vocational expert and a vocational expert opinion is needed to make a finding on employability issue.

The board further pointed out that neither party presented substantial evidence on the issue of apportionment under LC §§ 4663 or 4664 based upon applicant's prior permanent disability award or an effect of applicant's pre-existing condition on current permanent disability and supplementary evidence was required from the agreed medical examiner on this issue.

27. Rating

Porter v. City & County of San Francisco (BPD) 2014 Cal. Wrk. Comp. P.D. LEXIS 77

The WCJ found the applicant was entitled to an award of 93% after apportionment.

The WCJ calculated the apportionment by finding the applicant 100% disabled apportioning 10% nonindustrial, therefore coming to a disability of 90% and modifying it for age and occupation to 93%.

Defendants filed a petition for reconsideration.

The WCJ reversed the WCJ. The WCAB found that the ratings of 100% permanent disability are not modified for age or occupation, and any adjustment for age and occupation occurs before application of apportionment. The WCJ's proposed rating was incorrect because he apportioned the standard rating rather than the adjusted rating.

Pursuant to Labor Code § 4663 the board found the applicant was entitled to 100% disabled which is the adjusted rating, apportioning 10% nonindustrial resulting in a rating of 90% permanent disability.

28. QME Panels

Razo v. Las Posas Country Club (BPD) 42 CWCR 43; ADJ 8381652

Applicant sustained a cumulative trauma injury while working as a driver for defendant. After the claim was denied a dispute arose as to the panel QME selection process. The internal QME panel issued on 1/3/13. Defendant struck a doctor on 1/11/13. Defendant designated another panel member to be the QME on 1/14/13. On 1/15/13 applicant exercised its right to strike a member of the panel. In orthopedics a panel was issued on 1/3/13. Defendant struck on 1/14/13 and designated one of the panel members to be the QME. On 1/15/13 applicant exercised his right to strike a panel member. Also at issue was the applicability of L.C. Section 4062.2(c). Whether the code Pre or Post SB 863 law was applicable.

The WCJ issued his decision finding that the former 4062.2(c) applied and also that applicant struck timely. Defendant filed a petition for reconsideration.

In its opinion the board found that under SB 863 the law is to apply to all pending matters, regardless of date of injury,...They state "Where a law makes changes relating to remedies or modes of procedure, rather than substance, the law applies to existing causes of action and defenses without having retrospective effect." They found that the panel QME process is procedural and therefore, the board determined that the current and newer version of the law was applicable.

They further held that CCP 1013 applied and allowed for 5 days for mailing after service of the assignment of the panel. They construed the statement in the code "assignment of the panel by the administrative director" to mean not only assignment but also service of the names of the panel QMEs on the parties by U.S. mail.

Pursuant to CCP 1013 when a party has a time limit to respond to a document received by U.S. mail, five calendar days is added so the party has a total of 15 days after assignment to strike a name from the QME panel.

In this case since the panel was assigned in 2013 the newer version of 4062.2 applies and since applicant struck on the 12th day after assignment it would be deemed timely. Removal was denied.

29. IMR

Bertrand v. County of Orange (BPD) 42 CWCR 20; ADJ 3135829

Applicant sustained an admitted CT. The parties stipulated to a 38% permanent disability and also stipulated that should any future disputes over treatment arise the parties would return to the AME, Lynn Wilson.

The matter proceeded to an expedited hearing in April of 2014 on the issue of an untimely UR denial and on the question whether the stipulation or the new IMR rules were applicable.

The Judge found that the right to UR may be contracted away. Defendant filed for reconsideration. The panel treated the petition as a removal.

The panel agreed with the Judge that the parties may waive their statutory right to a review process and use an AME on a treatment issue but determined that defendant must first seek UR before proceeding to the AME. IMR of a UR denial may be bypassed and does not override a lawfully entered stipulation. However, the stipulation does not avoid the entire UR process. The panel determined that to send the case to the AME there must first be a dispute over medical treatment which means UR must first deny the request. The panel granted removal and amended the F&O to allow submission to UR with a subsequent dispute must precede referral of the dispute to the AME.

30. Panel QMEs

Garcia v. Alameda Unified School District (BPD) 2014 Cal. Wrk Comp. P.D. LEXIS 347

The Brown case summarized below stands for the proposition that if defendants are the first to make a request for a panel and it is in a specialty different than the Primary Treating Position that request is proper as long as supported by relevant documentation as required by regulation 31.1 (b).Section 31.1 (b) provides that in the event a party in a represented case wishes to request a QME panel pursuant to LC 4062.2 is specialty other than the specialty of the treating physician, the parties shall submit with the panel request form any relevant documentation supporting the reason for requesting a different panel.

The WCJ found that defendants December 2, 2013 request for a QME panel in the specialty of psychiatry was not defective and the parties were bound to that assigned panel, which was issued months before the medical unit issued a second QME panel in the specialty of psychology pursuant to applicants panel request.

Applicant filed a petition for removal which was denied.

The applicant's attorney argued the first panel in psychiatry was invalid on the basis that the specialty was different from the treating physician specialty of psychology.

The WCAB found that in cases such as this where applicant is represented, any party may request a qualified medical evaluator in any specialty pursuant to Labor Code § 4062.2 and there is no requirement the qualified medical evaluator panel be in the same specialty as the specialty of the treating physician.

Regulation 31.1 (a) setting forth the tie-breaking procedure when two or more panel selection forms designate different specialties are received by the medical unit on the same day does not apply in this case because the parties stipulated that defendant was the first time to send its request for a psychiatric panel and the psychiatric panel was issued first.

Defendant's request for a panel in a different specialty than the treating physician was supported by relevant documentation as required by regulation 31.1 (b) which was applicable here, because defendant submitted a letter with the panel request indicating that applicant was hospitalized and treated by a psychiatrist earlier this year and letter was supported by Kaiser records, and that because the first QME panel was valid and not revoked pursuant to rule § 30 (c), the second qualified medical panel issued by the Medical Unit in specialty of psychology was issued in error.

31. Rating

Tallent v. Infinite Resources (BPD) 2014 Cal. Wrk. Comp. P.D. LEXIS 141

The WCJ relied on an opinion of a chiropractic panel QME to rate permanent disability caused by applicant's back, neck and psyche injury.

Defendants argued that the PQME, as a licensed chiropractor, was not qualified to provide opinions on any impairment regarding neurological or sensory disorders, sleep, chronic pain, scarring effects of medication usage and was limited to commenting on the AMA guide impairments that fall strictly within the scope of the chiropractic treatment.

The WCAB upheld the WCJ. The WCAB found that chiropractic PQME's were competent and statutorily bound to utilize all sections of the AMA guides to provide an opinion on impairment that most accurately described applicant's condition. The WCAB indicated that all panel QME's in order to obtain licensure, must undertake testing informal training and use of the AMA guides and preparation of evaluation reports, and, to provide expert opinion using appropriate sections of the AMA guides.

In some cases physicians will utilize areas of the AMA guides that are not specifically within their area of practice. The WCAB indicated that to bar a licensed QME from use of certain sections of the AMA guides solely because he is a chiropractic practitioner would be discriminatory and in conflict with the case law interpretations that injured workers are due the most accurate depictions of their impairment within the AMA guides. The Chiropractic PQME's opinions regarding the applicant's impairments in this case were adequately described within the four corners of the AMA guides and consistent with the medical record, and constituted substantial evidence to support the WCJ's permanent disability determination.

32. Medical Treatment

Robertson v. Bonnano (BPD) 2014 Cal. Wrk. Comp. P.D. LEXIS 443

The WCAB held that a defendant was liable for right hip replacement surgery, even though the defendant deferred UR on the grounds that it was disputing compensability for the right hip, because the defendant did not timely object to the treating physician's request for surgery by requesting an AME or QME under LC 4062.

The WCAB explained that under *Simmons v. State of California, Dept. of Mental Health (Metropolitan State Hospital)* (2005) 70 CCC 866 (appeals board en banc), in which the treatment prescribed relates to a disputed body part that the physician has explicitly or implicitly found to be industrial, the defendant must initiate the AME/QME procedure under LC 4062(a) within the time limits prescribed in that subsection.

The WCAB added that if the employer did not dispute a medical determination within that time limit, it could not attack the determination thereafter. The WCAB found substantial evidence supported compensability of the right hip injury. It added that even if the records were not substantial evidence, because the defendant did not object to the treating physician's request within the time prescribed by LC 4062(a), it could not attack the implicit determination of industrial causation thereafter.

33. Procedure

Solis v. Ameron International (BPD) 2014 Cal. Wrk. Comp. P.D. LEXIS 181

The WCJ found that applicant was not barred from claiming a psychiatric injury as a compensable consequence of earlier admitted injury to the head, neck and low back on September 26, 2007.

Defendant filed a petition for reconsideration.

The WCAB affirmed the WCJ.

The applicant first claimed psychiatric injury on July 17, 2013 at the mandatory settlement conference. The WCAB found the applicant was not claiming a new injury, but rather an injury to an additional body part.

There was no dispute that the underlying claim was timely filed, that defendant was not unduly prejudiced by claim of injury because it had notice and knowledge of psychiatric symptoms to his psyche from medical reporting and received before applicant claimed the psychiatric injury.

Applicant's failure to amend the application identifying injury to psyche before the July 17, 2013 mandatory settlement conference did not result in a waiver of a psychiatric claim.

The claim of injury to the psyche raised at the mandatory settlement conference was not inconsistent with the provisions of LC § 5502.

The WCAB did not agree with the WCJ's determination that the statute of limitation was tolled by filing of an underlying claim, nor that defendant status as self-insured, self-administered employer was of special significance in concluding that it did not incur undue prejudice. Duty to investigate under regulation 10109 is the same for self-insured employer as it is for insurers.

34. Medical Treatment

Acosta v. Balance Staffing (BPD) 2014 Cal. Wrk. Com. LEXIS P.D. 480

This matter proceeded to expedited hearing on the issue of whether the applicant's medical treatment had been terminated by the MPN Primary Treating physician and whether the applicant is entitled to select another physician within the MPN, without resorting to the QME process. The matter was submitted without testimony.

The WCJ found that the Primary Treating Position within the MPN issued a complete release of applicant from care and that the procedure in LC § 4616.3 (c) does not apply to allow applicant to select a second and a third MPN physician and that the panel QME process must be followed to resolve the dispute over whether the applicant is still in need of treatment.

Applicant filed a petition seeking reconsideration.

The issue before the WCAB was whether applicant may follow the dispute resolution process through the MPN when the applicant is no longer in need of medical treatment or whether the applicant must follow the panel QME process and LC § 4062.

The WCAB concluded that an MPN physician's determination that an injured worker is no longer in need of medical treatment does not constitute a dispute over diagnosis or a recommendation for medical treatment and therefore the applicable administrative director rules mandate the parties follow the panel QME process to resolve the dispute over the physician's determination, not the MPN dispute resolution process contained in LC 4616.3 and 4616.4

If the employer has created a valid MPN the injured worker generally is limited to selecting their medical providers within the employer's network, absent a neglect or refusal to provide reasonable and necessary medical treatment as required by LC 4600. If an injured worker disputes either the diagnosis or the treatment prescribed by the treating MPN physician, pursuant to section 4616.3 (c), the injured worker is entitled to seek the opinion of another physician from within the employer's MPN and in addition the section allows injured workers to seek a third physician within the MPN if the injured worker disputes the diagnosis or treatment prescribed by the second physician.

Contrast to that is Labor Code section 4062 (a) which provides a separate dispute resolution process for disputes over a medical determination made by the treating physician concerning any medical issues not covered by section 4060 or 4061 and not subject to 4610 and LC 4062.2 (b). The section requires the parties to select either an AME or utilize a panel QME to resolve the disputed medical issue, rather than allowing an injured worker to seek a change of physician to obtain different medical determination.

The WCJ in this case found the dispute resolution provisions of 4616.3 (c) are not applicable in the case because applicant was released from further treatment by the primary treating physician and there was no dispute over diagnosis or treatment prescribed by the treating physician.

The WCJ ruled that rule 9785 (b) (3) mandates the use of the procedures set forth in Labor Code section 4061 and 4062 to resolve disputes over medical determination, which is defined in rule 9785 (a) (4), include medical issues such as the decision whether to release an injured worker from care.

In this case the board held the MPN's physician made a determination that recommended a complete discharge release from care. Therefore this is a dispute that must be resolved applicable procedures in section 4062.

Applicant is not entitled to rely upon rules that pertain to a change of treating physician which apply only when it dispute is over diagnosis or treatment prescribed by the treating physician.

A physician's release of the injured worker from all further care cannot be equated with a dispute over diagnosis of medical condition or prescription for treatment of that condition.

Therefore the board concluded the parties must follow the dispute resolution process in LC 4062, and may not select another physician from within the MPN to resolve the dispute.

Accordingly they affirmed the WCJ's decision.

35. Settlement

Chott v. Safety National Casualty (BPD) 42 CWCR 149

Applicant claimed to have sustained a cumulative psychiatric injury in the course of her employment. A claims adjuster for defendant propose settling applicants claim for \$5000 and send an unsigned compromise and release form for that purpose to the applicant. On March 27, applicant signed and mailed the compromise and release agreement to the adjuster. The next day, the applicant called the adjuster and left a message requesting further discussion of the settlement agreement. Applicant subsequently left many messages indicated she wanted to back out of the settlement. Defendant nevertheless signed the compromise and release and filed the settlement with the WCAB. The WCJ approved the settlement.

Applicant sent a letter to the Presiding WCJ that she wanted to set aside the order approving compromise and release because she still had medical problems.

The WCJ heard the unrepresented applicant's testimony about her continued unsuccessful efforts to contact the claims adjuster to discuss the compromise and release. The next day, the WCJ filed a findings and order setting aside the order that had approved the settlement.

Defendants filed a petition for reconsideration. Defendants argued that the WCJ erred in setting aside the settlement because the applicant had not petition for reconsideration and in the absence of a showing of fraud, duress, or mistake of fact, an order approving a settlement cannot be vacated.

The WCJ recommended that reconsideration be denied writing that she would not have approved the compromise and release had she been aware of the facts. Applicant credibly testified about the many time she had attempted to talk to the claims adjuster and about her desires, before the claims adjuster had signed and filed the settlement to back out of the agreement. When the adjuster received word of applicant's wishes she should have contacted applicant to discuss the matter further. Instead the claims adjuster ignored the requests of the applicant and signed the settlement documents and forwarded the settlement to the WCAB for approval.

The WCAB construed applicant's letter to the PWCJ has a petition for reconsideration of the order approving the compromise and release agreement. The WCAB conceded that the board first learned of the letter more than 60 days after been filed. Pursuant to Labor Code § 5909, the passing of 60 days after the filing of a petition for reconsideration without action by the board is considered a denial the petition by operational law, but reasoned that the delay had not been applicant's fault and should not affect the right of her petition for reconsideration to be considered on the merits citing the case of Shipley v. WCAB 57 CCC 493.

The panel explained that when an order approving compromise and release has become final, it may be rescinded only if there is a showing of good cause such as fraud, duress, undue influence, or mutual mistake of fact. When the order comes before the board on a petition for reconsideration, however, the board powers are much more extensive.

The board may amend or rescind the order on the record for newly obtained evidence. One of the grounds for reconsideration is that the WCJ's order was not justified by the evidence.

Pursuant to the case of *Redner v. WCAB* (36 CCC 371) the board has considerable discretion enjoys broad authority to correct injustices on reconsideration. The board is not limited to a finding of fraud, duress undue influence or mutual mistake of fact.

As the WCJ observed that pursuant WCAB Rule 10859 applicant's un rebutted testimony would have justified a rescission of the WCJ's order approving the compromise and release agreement. Applicant revoked her offer to settle before it had been accepted by communicating the revocation in a message to the claims adjuster and by multiple attempts to speak to the claims adjuster before the compromise and release was filed for approval.

Defendants failure to respond to any of applicant's messages for several months and its failure to inform the WCJ that applicant had revoked her offer justified the conclusion that the compromise and release was not duly executed in accordance with § 5003.

The WCJ granted reconsideration of the letter written to the PWCJ and rescinded the WCJ's order approving the compromise and release and the order setting aside the approval and substituted a finding that there was good cause to set aside the order approving the compromise and release.

The WCAB dismissed defendant's petition for reconsideration as being moot.

36. Credit

Franco v. California Business Forms (BPD) 2014 Cal. Wrk. Comp. P.D. LEXIS 57

The WCJ ordered a partial rather than full credit to defendants for overpayment of PD to applicant.

The WCAB agreed with the WCJ finding that defendant changed the rate of applicant's PD payments without any notice or explanation to applicant and without notice of intent to seek credit for alleged overpayments, that overpayment was due entirely to defendant's unilateral mistake in adjusting applicants claim and the WCAB concluded that granting the credit was within the WCJ's discretion, and that allowing the credits claimed by defendant would cause applicant extraordinary hardship.

BOARD PANEL DECISIONS

37. Utilization Review

Stock v. Camarillo State Hospital (BPD) ADJ 2426407

Defendants received a medical treatment request from a MPN physician. Defendants sent the request to utilization review.

The applicant argued that the report should not be admitted on the basis that the defendant was not permitted to contest any medical treatment prescribed by MPN physicians. Defendants cannot send a treatment request from an MPN physician to utilization review. At trial the Judge found the UR report admissible. Applicant filed for reconsideration.

The WCAB held that the defendant's utilization review (UR) determination of a request submitted by a treating physician in the defendant's medical provider network (MPN) was admissible over the applicant's objection. The WCAB found that, contrary to the applicant's argument, the Legislature did not demonstrate an intent to preclude employers from seeking UR of MPN physicians' requests for authorization of medical treatment.

The statutory and regulatory law governing UR and MPN provisions provide that a treating physician's request for authorization of medical treatment must be reviewed by a physician competent to evaluate the specific medical issues, without distinction as to whether the treating physician is selected through an MPN.

Furthermore, the definition of "primary treating physician" in 8 Cal. Code Reg. §§ 9767.1 and 9785(a)(1) both include physicians within an MPN. When an employer does not approve a treatment request from an applicant's "primary treating physician," the defendant must refer the request to UR.

According to the WCAB, further review of the treating physician's request for a hospital bed to cure or relieve the effects of the applicant's back injury must occur through independent medical review.

The UR denial was based upon "silence" in the Medical Treatment Utilization Schedule guidelines, and the absence of "high quality studies" and "exceptional factors" in the documentation submitted to consider this request as an outlier to the guidelines. Moreover, it did not appear to consider other standards applicable in reviewing requests for authorization (i.e., nationally recognized professional standards, expert opinion, generally accepted standards of medical practice, and treatments that are likely to provide benefit for the condition for which other treatments are ineffective) as there was insufficient documentation or explanation provided to support the effectiveness of treatment in the form of a hospital bed.

The Judge's decision was affirmed.

38. Labor Code Section 4061(i)

Franco v. Clougherty (BPD) ADJ6727707

Applicant sustained an admitted CT while working as a hog handler from 12/1/07 through 4/24/09. Applicant's primary treating doctor, Dr. Sobol, issued a P&S report on 11/27/12. Applicant filed a DOR on 5/23/13 on multiple issues including permanent disability and future medical care. Defendant timely objected arguing Sobol's report was not served until 5/16/13 and defendant had a right to a QME. The matter was set for MSC on 7/18/13. At the MSC defendant requested that a QME evaluation be scheduled. The matter was set for trial. At issue was whether defendant had the right to the QME and if there was a timely objection to the PTP report. The WCJ found that the defendant had timely objected to the report but had waived the right to the QME evaluation since they failed to schedule it. Defendant filed for reconsideration.

The board looked at Labor Code Section 4061(i) which states that a DOR that raised the issue of P.D. may not be filed "unless there has first been a medical evaluation by a treating physician and by either an AME or QME". There had been no evaluation by an AME or QME in this case. They further found that there had been no waiver of defendant's right to have applicant evaluated by a QME. Pursuant to L.C. 4062.2 it is the responsibility of the represented applicant to schedule the evaluation. If the applicant fails to do so timely the employer may arrange for the appointment, however, this is not mandatory. The applicant did not arrange for the evaluation and the record showed that defendant had requested the QME in the objection to the DOR. They concluded that defendant had not waived its rights. The petition was granted and the matter returned to the WCJ for further proceedings.

