WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

DONALD SWEETNAM, *Applicant*

vs.

COUNTY OF LOS ANGELES, permissibly self-insured, administered by SEDGWICK CLAIMS MANAGEMENT SERVICES, *Defendants*

Adjudication Numbers: ADJ10595392, ADJ10596376, ADJ11367370
Van Nuys District Office

OPINION AND ORDER DENYING PETITION FOR RECONSIDERATION

Defendant seeks reconsideration of the Amended Joint Findings and Award and Order issued by the workers' compensation administrative law judge (WCJ) on March 25, 2022, wherein the WCJ found in pertinent part the injury claims in case number ADJ10596376 and case number ADJ11367370 were subsumed into the cumulative injury claim in case number ADJ10595392, that the injury in case number ADJ10595392 caused 73% permanent disability, and that defendant's request for credit for the claimed temporary disability indemnity overpayment was denied.

Defendant contends that the April 7, 2021 report from Laura Hatch, M.D., should not be admitted into evidence, that Dr. Hatch improperly rated applicant's shoulder impairment, and that defendant should be given credit for a temporary disability indemnity overpayment.

We received a Report and Recommendation on Petition for Reconsideration (Report) from the WCJ recommending the Second Petition for Reconsideration (Petition) be denied. We received an Answer from applicant.

We have considered the allegations in the Petition and the Answer and the contents of the Report. Based on our review of the record, and for the reasons stated by the WCJ in the Report, which we adopt and incorporate by this reference thereto, we will deny reconsideration.

For the foregoing reasons,

IT IS ORDERED that defendant's Petition for Reconsideration of the Amended Joint Findings and Award and Order issued by the WCJ on March 25, 2022, is **DENIED**.

WORKERS' COMPENSATION APPEALS BOARD

/s/ KATHERINE A. ZALEWSKI, CHAIR

I CONCUR,

/s/ MARGUERITE SWEENEY, COMMISSIONER

/s/ KATHERINE WILLIAMS DODD, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

June 20, 2022

SERVICE MADE ON THE ABOVE DATE ON THE PERSONS LISTED BELOW AT THEIR ADDRESSES SHOWN ON THE CURRENT OFFICIAL ADDRESS RECORD.

DONALD SWEETNAM
STRAUSSNER & SHERMAN
LOS ANGELES COUNTY COUNSEL

TLH/*pc*

I certify that I affixed the official seal of the Workers' Compensation Appeals Board to this original decision on this date. *abs*

JOINT REPORT AND RECOMMENDATION ON PETITION FOR RECONSIDERATION

INTRODUCTION

Defendant filed a timely verified Petition for Reconsideration, dated April 18, 2022 in response to the Opinion on Decision and Findings and Award, dated March 23, 2022.

DEFENDANT CONTENDS:

I. DR. HATCH'S APRIL 7, 2021 REPORT SHOULD BE EXCLUDED FROM EVIDENCE PURSUANT TO LABOR CODE §5502((D)(3) AND THE EQUITABLE PRINCIPLES OF WAIVER AND INVITED ERROR.

The parties proceeded to Mandatory Settlement Conference on January 4, 2021. Two weeks earlier, on December 22, 2020, defense counsel requested a DEU Consultative Rating pursuant to the Board File. According to applicant's brief, the ratings were served by defense counsel on February 11, 2021, and subsequently, applicant counsel filed a Petition to Re-Open discovery, dated March 23, 2021, based upon the recently served consultative rating. (EAMS Doc ID 36022795) Said Petition included interrogatories to Dr. Hatch.

Thereafter, WCJ Glass issued a Joint Order for Additional Discovery, dated 03/23/2021 pursuant to Labor Code Section 5701, regarding the proposed interrogatory to IME Hatch to address the DEU consultative rating of January 7, 2021. The Rater's comments were served upon applicant counsel after the close of discovery (MSC).

Pursuant to Labor Code Section 5502 (d)(3):

> If the claim is not resolved at the mandatory settlement conference, the parties shall file a pretrial conference statement noting the specific issues in dispute, each party's proposed permanent disability rating, and listing the exhibits, and disclosing witnesses. Discovery shall close on the date of the mandatory settlement conference. Evidence not disclosed or obtained thereafter shall not be admissible *unless the proponent of the evidence can demonstrate that it was not available or could not have been discovered by the exercise of due diligence prior to the settlement conference*. (Emphasis added)

Furthermore, if parties fail to submit substantial medical evidence on a relevant issue, the Workers' Compensation Appeals Board may reopen the record and develop it further to allow for a complete adjudication. (Lab. Code,

§§ 5502 subd. (e)(3), 5701 & 5906; *Marsh v. Workers' Comp. Appeals Bd*. (2005) 130 Cal.App.4th 906, 916, fn. 7 [70 Cal.Comp.Cases 787]; *San Bernardino Community Hospital v. Workers' Comp. Appeals Bd.* (*McKernan*) (1999) 74 Cal.App.4th 928, 935 [64 Cal.Comp.Cases 986]; *Tyler v. Workers' Comp. Appeals Bd.* (1997) 56 Cal.App.4th 389, 394 [62 Cal.Comp.Cases 924].) The preferred method for developing the record was addressed in *McDuffie v. Los Angeles County Metropolitan Transit Authority* (2002) 67 Cal.Comp.Cases 138, 142 (en banc).

Historically, the WCAB was obligated to not leave issues undeveloped which it acquired, specialized knowledge should identify as requiring further evidence. (West v. Industrial Acc. Com. (1947) 79 Cal.App.2d 711 [180 P.2d 972, 12 Cal. Comp. Cases 86] [medical opinion regarding causation and disability inadequate, requiring additional medical evidence]; Raymond Plastering v. Workmen's Comp. App. Bd. (1967) 252 Cal.App.2d 748 [60 Cal. Rptr. 860, 32 Cal. Comp. Cases 287] [further evidence of earnings needed when not established by employee's testimony]; Lundberg v. Workmen's Comp. App. Bd. (1968) 69 Cal.2d 436 [445 P.2d 300, 71 Cal. Rptr. 684, 33 Cal. Comp. Cases 656] [industrial injury inferred by facts [**23] and additional evidence required under sections 5701 and 5906 where one physician did not address causation and another opinion was equivocally]; Rushing v. Workmen's Comp. App. Bd. (1971) 15 Cal.App.3d 517 [92 Cal. Rptr. 605, 96 Cal. Rptr. 756, 36 Cal. Comp. Cases 49] [employee's history of no pain just after the injury did not foreclose symptoms later, requiring further medical evidence under sections 5701 and 5906]; Adams v. Workmen's Comp. App. Bd. (1971) 22 Cal.App.3d 214 [99 Cal. Rptr. 269, 36 Cal. Comp. Cases 784] [physician's report susceptible of several interpretations should be clarified under section 5701]; Zozaya v. Workmen's Comp. Appeals Bd. (1972) 27 Cal.App.3d 464 [103 Cal. Rptr. 793, 37 Cal. Comp. Cases 575] [proper to appoint independent medical examiner under section 5906 to resolve conflict in medical evidence].)

Based upon the above discussion, it was found that applicant did act with due diligence, was not aware of the DEU Consultative Rating prior to service after the Mandatory Settlement Conference on January 4, 2021, and thus this evidence was not available or could not have been discovered by the exercise of due diligence prior to the settlement conference. The Report of IME Laura Hatch, M.D., dated 4/7/2021, was marked for identification only, and later admitted into evidence as Court's Exhibit A.

II. THE STRENGTH IMPAIRMENT AS PROVIDED BY DR. HATCH IS IMPROPER PER CHAPTER 16.8A OF THE AMA GUIDES (PAGE 508).

Dr. Hatch's report goes into great detail why she deviated from the strict AMA guides impairment. Moreover, case law does not require that the doctor provide explanations on why more objective measurements were not performed

in providing an Almaraz/Guzman analysis. In *Almaraz v. Environmental Recovery Services/Guzman v. Milpitas United School District* (2009) 74 Cal. Comp. Cases 1084 (en banc), an impairment rating under the AMA Guides can be rebutted by "challenging any of the individual component elements of the formula that resulted in the employee's scheduled rating." [*Id*. at p. 1101] The Sixth District Court of Appeals, in affirming the WCAB, held that whole person impairment could be challenged through the presentation of evidence that a different chapter, table, or method in the Guides more accurately describes the impairment" and is within the four corners of the AMA Guides. *Almaraz v. Environmental Recovery Services /Guzman v. Milpitas United School District* (2009) 74 Cal. Comp. Cases 837, 844] It also held that: "In order to support the case for rebuttal, the physician must be permitted to explain why departure from the impairment percentages is necessary and how he or she arrived at a different rating. That explanation necessarily takes into account the physician's skill, knowledge, and experience, as well as other considerations unique to the injury at issue… But [w]ithout a complete presentation of the supporting evidence on which the physician has based his or her clinical judgment, the trier of fact may not be able to determine whether a party has successfully rebutted a rescheduled rating or, instead, has manipulated the Guides to achieve a more favorable impairment assessment." (*Id.*, at p. 854)

In, *Milipas Unified School Dist. V. WCAB* (Guzman III) (2010) 187 Cal.App.4th 808, 822, Guzman III further provides that in order to support the case for rebuttal [of the AMA Guides], the physician must be permitted to explain why departure from the impairment percentage is necessary and how he or she arrived at a different rating. *Guzman III*, 187 Cal.App. 4th, 822, 828-829. The court in *Guzman III* provided that in order to rebut the strict application of the American Medical Association (AMA) Guides to the Evaluation of Permanent Disability (5th Edition), the doctor is expected to : (1) provide a strict rating per the AMA Guides; (2) explain why the strict rating does not accurately reflect the applicant's disability; (3) provide an alternative rating using the four corners of the AMA Guides; and (4) explain why that alternative rating most accurately reflects the applicant's level of disability. (Id. At 828-829) Moreover, in *Frazier v. State of California Department of Corrections and Rehabilitation* 2013 Cal. Wrk. Comp. P.D. Lexis 487, the court's allowed a physician to utilize Almaraz/Guzman to provide a lower rating, not just a higher rating. The WCAB in *Frazier* allowed the physician to utilize the Sixth Edition of the Guides, but then granting reconsideration on its own motion and reversing that decision. However, what was not challenged by any party or the WCAB in that case, was the physician's ability to provide a lower WPI rating.

In her report of report of April 7, 2021 Dr. Hatch stated:

Regarding his right shoulder, an impairment rating was derived on page 20 of my November 1 6, 2020 report. To reiterate, right shoulder x-rays revealed slight superior elevation of the humeral head within the glenoid fossa, which is

suggestive of chronic rotator cuff insufficiency. As stated inthe March 26, 2020 report, in September of 2018, he underwent a right shoulder MRI which revealed a high-grade rotator cuff tear with bicipital instability consistent with a biceps partially medially subluxed and degenerative signal in a superior biceps labral complex with full-thickness chondral defects of the superior to the posterior humeral head. These are significant right shoulder MRI findings.

As outlined on page 20 of my November 2016 report, he had a mild loss of motion which corresponded to only a 1% upper extremity impairment. However, due to his right shoulder pain, as stated in my 2016 report: "He reports difficulty reaching across his body such as to wash his contralateral extremity or reaching behind him. He reports that he is aware of right shoulder pain when retrieving milk from the fridge or reaching into high cabinets and alters the manner in which he does this. When he descends stairs, he holds onto the handrail which can be painful to his right shoulder.

He reported when he was working he had significant difficulties lifting the extension ladders off the hooks at work and often needed assistance. He states that the intensity of his night pain has subsided somewhat since he discontinued working, but he continues to note some aching, throbbing pain at night."

Clearly, this 1% upper extremity impairment derived from the loss of motion is not an accurate reflection of the burden of his right shoulder condition. He was found to have a high-grade rotator cuff tear, bicipital instability, and full-thickness chondral defects. In other words, it is not just his rotator cuff that is injured, but also the glenohumeral joint substantiating the use of a loss of strength in addition to the loss of motion when deriving his impairment rating. His 1% upper extremity impairment is not an accurate reflection of the burden of his right shoulder condition.

Therefore, the loss of strength method should be utilized and combined with the loss of motion as outlined on page 28 of my November 2016 report. (Emphasis added)

As it pertains to his left shoulder, x-rays obtained in March of 2020, revealed superior elevation of the humeral head within the glenoid fossa, glenohumeral joint space narrowing, and osteophyte formation consistent with rotator cuff arthropathy. A left shoulder MRI obtained in November of 2018, in brief, revealed glenohumeral joint osteoarthritis and Grade 111/1V chondromalacia. There was a high-grade SLAP tear and large clusters of paralabral cysts. There was partial tearing of the infraspinatus and supraspinatus. (id. p. 2)

As outlined on pages 23 and 24 of my March 2020 report, his loss of motion only corresponded to a 2% upper extremity impairment. Due to his left shoulder pain, he can no longer vacuum using his left arm. He is more limited in his sleeping position due to his left shoulder pain. He feels unable to lift

weights or lift a case of water, etc. A 2% upper extremity impairment is not an accurate reflection of the burden of his left shoulder condition. He has substantial x-ray and MRI findings clearly substantiating his pain complaints. *Therefore, an impairment rating via an Almaraz Guzman Analysis incorporating the loss of strength is reasonable. In addition, these are two different pathomechanisms. The loss of motion can be considered due to the rotator cuff pathology. The loss of strength can be in part due to the glenohumeral joint pathology. Therefore, my impairment ratings, as outlined on pages 23 and 24 of my March 2020 report, remain unchanged.* (Emphasis added)

Regarding the lumbar spine, the Disability Evaluation Unit evaluator states: "'Lumbar range of motion method requires multi-level involvement evidenced by multi-level radiculopathy, multi-level surgery, multi-level fracture, recurrent radiculopathy, or bilateral radiculopathy. Lumbar spine rating per range of motion as given by the doctor; however, DRE method may be applicable. If the range of motion method is applicable, doctor should evaluate impairment per all three components of the range of motion method; range of motion diagnosis and nerve root. There is no 6% WP in Table 15-7 for said impairment, doctor should choose between WP or 7% WP clarification as needed.

As outlined on page 24 of my March 2020 report, his lumbar spine x-rays revealed multi-level degenerative changes. As this is multi-level pathology in the same spinal region, an impairment rating is reasonably derived via the range of motion method. This pathology is not well characterized via the DRE method.

Page 379 of the AMA Guides states the range of motion method is to be used in several situations, including when an individual cannot be easily categorized in a DRE class. In addition, on page 380, the range of motion method is to be used when there is multi-level involvement in the same spinal region, Examples of this are fractures at multiple levels, disc herniations, or stenosis with radiculopathy at multiple levels or bilaterally. These examples are not all-inclusive. *Due to the multi-level pathology in the same spinal region, including multilevel degenerative changes which are not well-characterized via the DRE method, he meets two of the criteria required to utilize the range of motion method for the lumbar spine*. (id. p. 3) (Emphasis added)

As it pertained to the second step in providing an impairment rating via the range of motion for the lumbar spine, this was provided according to Table 15-7, page 404. His lumbar spine x-rays revealed diffuse mild to moderate degenerative changes. According to Table 15-7, page 404, none to minimal degenerative changes on structural tests corresponds to a 2B or 5% whole person impairment. Moderate to severe degenerative changes on structural tests corresponds to a 2C or 7% whole person impairment. As he had mild to moderate degenerative changes, a number interpolated between the two is 6%

whole person impairment is reasonable and has what I derived my impairment rating. However, if I was forced to choose between the two, I would choose 2C at a 7% whole person impairment.

I note on page three of the Consultative Rating Determination that if the range of motion method is applicable, the doctor should evaluate impairments per all three components of a range of motion; a range of motion, diagnosis, and nerve root. The nerve root/neurological section is only applied if there is clear neurological involvement, such as clear motor strength or sensory loss. In this case, that is not applicable.

My impairment rating, as derived on page 24 of my March 2020 report, remains unchanged. Id. p. 3-4)

Dr. Hatch was deposed two times, once on June 12, 2019 and again on September, 16, 2020. (Exhibits G and F respectively)

In the January 12th deposition, Dr. Hatch opined:

> Q And you believe that the Almaraz/Guzman analysis is the most accurate way to describe the right ankle impairment; is that correct?
>
> A Yes…
>
> Impairment ratings derived from Almaraz/Guzman included his complaints of pain. (id. pg. 26)
>
> Q So in this report you did note that -- this is the first report -- that he was MMI at your evaluation. Therefore, he would no longer be temporarily totally disabled; correct?
>
> A Correct. Unless things changed. From what I knew at the time I evaluated him, correct.
>
> Q *What type of things would change to revert him back to that temporary total disability period*?
>
> A *If things deteriorated and he decided to proceed with surgical intervention.*
>
> Q *But he could very well have further degeneration and further complaints but not seek surgical intervention if he chose to; right*?
>
> A *Correct.*

Q *So if you were to -- hypothetically to review further progress reports that noted a change in his condition after the time you evaluated him, you would defer to his reports whether he was temporarily totally disabled; is that correct?*

A *Yes.* (id. pg. 27-28) ((Emphasis added)

In her September, 16, 2020 deposition, Dr. Hatch opined:

> On page 21 of my 2020 report, the last sentence of the third paragraph: "Although he denies a change in his right ankle condition, he describes more functional limitations in his weight-bearing tolerance."
>
> So in other words, sometimes because these things evolve slowly patients kind of forget where they were four years before. And so I'd ask him to give specific examples. So based on his difficulties performing activities of daily living, which he did not express to me so clearly, at least in 2016, in combination with the advancement of the degenerative changes, I readdressed the impairment rating. (id. pg. 13)
>
> … And when I saw him in 2020, he described that his low back pain was a two to three out of ten on average but that he would experience severe flare-ups at that time of a six to seven.
>
> And the flare-ups could last a few weeks during which time he could be guarded and would cancel all scheduled activities and social obligations, et cetera. He felt he had reported more difficulties with driving more than 20 to 25 minutes, which is something he hadn't described before. He felt unable to scrub the bathtub, which is not something he had described before. So although he might have told my historian that he had improved, he certainly described to me as a change in his function. And therefore, I've readdressed his impairment rating. (id. pg. 20)
>
> Two last questions, Doctor. You found applicant MMI at the November 16, 2016, evaluation; correct?
>
> A Correct.
>
> Q And that continues to be the date you find applicant was MMI; correct?
>
> A Yes.

> A Here is a slow, gradual decline since then, but he hasn't undergone surgery or any major events. (id. pg. 25-26)

The Hatch report is methodical and well-though out; and clearly, to the undersigned, substantial medical evidence.

III. TO PREVENT DOUBLE RECOVERY AND UNJUST ENRICHMENT, THE COUNTY SHOULD BE AWARDED THE FULL TD OVERPAYMENT OF $69,448.94.

CREDIT FOR TEMPORARY DISABILITY OVERPAYMENT

IME Hatch found the applicant at maximum medical improvement on November 16, 2016, as written in her evaluative report of the same date. (*Id*. pg. 19.) This report included permanent work restrictions regarding the right shoulder, lumbar spine, and right ankle. (*Id*. pg. 20.) Dr. Hatch's report was served on the applicant's attorney and defendant's third-party administrator on December 13, 2016, pursuant to the attached proof of service at the end of the report. However, the applicant's Primary Treating Physician, Dr. Daniel Kharazzi, continued to treat the applicant's shoulder and considered his work status as TTD pursuant to Court's J – L; with the Kharazzi report of 10/17/2018(Court's I) indicating that applicant was "currently retired."

Pursuant to Tristar benefit notice, dated 5/9/2018 (Exhibit N):

> Payments of temporary disability benefits are ending because you were declared permanent and stationary effective 11/16/2016 by Independent Medical Evaluator, Laura Hatch. Benefits have been paid to you in the amount of $69,448.94 from 03/31/2017 through 05/10/2018 at the rate of $1,128.43 per week. Please see the attached detailed payment record for specific periods and amount paid. A copy of the report is attached to this notice.
>
> Included in this amount is an overpayment totaling $69,448.94. The overpayment was paid for the periods) from 03/31/2017 through 05/10/2018 at the rate of $1,128.43 per week. We will be asserting our right to a credit for this overpayment against any award you may receive.

The right to a credit is enunciated in Labor Code § 4909.

> Any payment, allowance, or benefit received by the injured employee during the period of his incapacity, or by his dependents in the event of his death, which by the terms of this division was *not then due and payable or when there is any dispute or question concerning the right to compensation, shall not, in the absence of*

> *any agreement, be an admission of liability for compensation on the part of the employer, but any such payment, allowance, or benefit may be taken into account by the appeals board in fixing the amount of the compensation to be paid*. The acceptance of any such payment, allowance, or benefit shall not operate as a waiver of any right or claim which the employee or his dependents has against the employer. (Emphasis added)

Pursuant to CCR § 10555. Petition for Credit:

(a) When a dispute arises as to a credit for any payments or overpayments of benefits pursuant to Labor Code section 4909, any petition for credit shall include:
(1) A description of the payments made by the employer;
(2) A description of the benefits against which the employer seeks a credit; and
(3) The amount of the claimed credit.
(b) When a dispute arises as to a credit for an employee's third party recovery pursuant to Labor Code section 3861, any petition for credit shall include:
(1) A copy of the settlement or judgment, if available; and
(2) An itemization of any credit applied to expenses and attorneys' fees pursuant to Labor Code sections 3856, 3858 and 3860.
(c) Where a copy of the settlement or judgment required under subdivision (b)(1) of this rule is not available, a workers' compensation judge may order its production for purposes of adjudicating a petition for credit under Labor Code section 3861.

The statutory duty to pay temporary disability compensation continues during the period in which an injured worker, while unable to work, is undergoing medical diagnostic procedure and treatment for an industrial injury. (*Braewood Convalescent Hospital v. Workers' Comp. Appeals Bd.* (1983) 34 Cal.3d 159, 168 [666 P.2d 14, 193 Cal. Rptr. 157, 48 Cal. Comp. Cases 566].) The duty ends when the worker is able to return to work or when his or her medical condition becomes permanent and stationary. (E.g., *Department of Rehabilitation v. Workers' Comp. Appeals Bd.* (2003) 30 Cal.4th 1281, 1291–1292 [70 P.3d 1076, 135 Cal. Rptr. 2d 665, 68 Cal. Comp. Cases 831].) "A disability is considered permanent when the employee has reached maximal medical improvement, meaning his or her condition is well stabilized, and unlikely to change substantially in the next year with or without medical treatment." (Cal. Code Regs., tit. 8, § 10152; *id*., § 9785, subd. (a)(8).) This is so even though further medical treatment may be required to relieve the effects of the injury. (See, e.g., 2 Witkin, Summary of California Law (10th ed. 2005) Workers' Compensation, § 287, pp. 895–897.) J.C. Penney Co. v. Workers' Compensation Appeals Bd.,

74 Cal. Comp. Cases 826, 830, 2009 Cal. Wrk. Comp. LEXIS 201, *9-11, 175 Cal. App. 4th 818, 96 Cal. Rptr. 3d 469.

When a dispute arises as to a credit for any payments or overpayments of benefits pursuant to Labor Code Section 4909, any petition for credit must include:

(1) A description of the payments made by the employer.
(2) A description of the benefits against which the employer seeks a credit.
(3) The amount of the claimed credit.

It is noted that there is no Petition for Credit is in evidence. Further, CCR 10555 mandates a petition for credit sought under LC 4909.

The statutory language allowing the credit actually states that benefits paid, but not due, "may" be taken into account by the Board in fixing future benefits owed. Similar language relating to liens has been held to be mandatory. The cases do recognize, however, certain situations in which credit for an overpayment will not be granted. Credit has been denied the employer on the basis of laches. When an employer unreasonably delays the filing of a medical report that terminates benefits, allowing the employee to receive excess benefits in good faith, equitable estoppel bars credit for overpayment. Credit has also been denied for temporary disability that was paid between the time the employee became permanent and stationary and the time the employer served the medical report so stating. *Similarly, a denial of credit against permanent disability payments is discretionary with the trial judge when allowing the credit would result in disruption or complete destruction of the purpose of permanent disability*. Thus, in a case in which the employer's overpayments of temporary disability benefits were due exclusively to its own error, and allowing a credit, except to the extent of the permanent disability benefit, would deprive the injured worker of approximately a year and four months of disability indemnity, the denial of credit was upheld as a valid exercise of judicial discretion. *CA Law of Employee Injuries & Workers' Comp* § 7.04 (2021) (Emphasis added)

The WCAB generally has some degree of discretion to grant or deny credit for overpayments under section 4909. (See, e.g., *Genlyte Group, LLC v. Workers' Comp. Appeals Bd*. (2008) 158 Cal.App.4th 705, 724 [69 Cal. Rptr. 3d 903, 73 Cal. Comp. Cases 6]; Herrera v. Workmen's Comp. App. Bd. (1969) 71 Cal.2d 254, 258 [455 P.2d 425, 78 Cal. Rptr. 497, 34 Cal. Comp. Cases 382].) However, we cannot sustain the denial of a credit beyond the limit based on section 4062 on equitable grounds. The only ground asserted in the WCAB award is section 4062. The WCAB did not otherwise assess the relative equities in either recognizing or denying full or partial credit. J.C. Penney Co. v. Workers' Compensation Appeals Bd., 74 Cal. Comp. Cases 826, 831-834, 2009

Cal. Wrk. Comp. LEXIS 201, 12-19, 175 Cal. App. 4th 818, 96 Cal. Rptr. 3d 469

In one case, the rationale of the denial of credit turns on public policy manifest in section 4062. The statute provides, in pertinent part, "If [the] employer objects to a medical determination made by the treating physician concerning any medical issues . . . , the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney . . . . These time limits may be extended for good cause or by mutual agreement." (§ 4062, subd. (a).)

A determination by a treating physician that an injured worker continues to be temporarily totally disabled is a medical determination subject to the objection requirement of Labor Code section 4062. (See Cal. Code Regs., tit. 8, § 9785.)

The question is: What is the effect of failing to object within the "time limits" of that statute? The requirement for an objection under section 4062 is stated in mandatory language: "the objecting party shall notify the other party in writing." The ordinary meaning of a mandatory time limit is that once the prescribed time has passed the action subject to the time limit may no longer be taken. When J.C. Penney failed to object to a medical determination of temporary total disability by Edwards's treating physician within the time limit provided in section 4062, it lost the right to object to that determination in the future.

The evident purpose of the time limits in section 4062 is to induce both employer and employee to declare promptly medical determination disputes and expeditiously resolve them through the prescribed mechanisms. This purpose cannot be attained if a party such as J.C. Penney can fail to object in a timely manner and nonetheless thereafter tender a claim that contradicts a medical determination subject to the objection requirement of the statute. *If either employer or employee fails to raise a dispute about a medical determination within the ambit of section 4062 within the prescribed time, they may not attack that determination thereafter*. (Emphasis added)

We find the core reasoning of the WCAB correct. "[I]t is contrary to the spirit of [section] 4062 to permit a retrospective determination of a permanent and stationary date" when to do so would be to allow a belated objection to a medical determination by the treating physician. J.C. Penney Co. v. Workers' Compensation Appeals Bd., 74 Cal. Comp. Cases 826, 831-834, 2009 Cal. Wrk. Comp. LEXIS 201, 12-19, 175 Cal. App. 4th 818, 96 Cal. Rptr. 3d 469

The Tristar benefit notice of 5/9/2018 that temporary disability benefits are ending, "because you were declared permanent and stationary effective 11/16/2016 by Independent Medical Evaluator, Laura Hatch," came nearly 1 ½ years after the fact. Defendant continued to pay TD benefits, presumably based

upon the reports of primary treating physician, Dr. Kharazzi. There is no evidence that defendant objected to any Kharazzi report pursuant to Labor Code Section 4062. (Court's Exhibit N)

Furthermore, in the case of California Indemnity Insurance Company, Silva Construction, Inc., Petitioners v. Workers' Compensation Appeals Board the Court of Appeal noted: "In this case, if credit were allowed defendant, the overpayment of temporary disability would deprive the injured worker of approximately a year and four months of disability indemnity, either at the inception of the award or at the end, assuming the overpayment were commuted. A lengthy hiatus in benefits would occur, either at the inception of the award, or at its end-assuming commutation of the overpayment. Such a hiatus is clearly not in the best interests of the applicant. *Since the error was exclusively that of the defendant, credit of the overpayment was not given except to the extent of the permanent disability benefit.*" California Indem. Ins. Co. v. Workers' Compensation Appeals Bd., 68 Cal. Comp. Cas 233, 2003 Cal. Wrk. Comp. LEXIS 84, 68 Cal. Comp. Cas 233, 2003 Cal. Wrk. Comp. LEXIS 84 (Cal. App. 4th Dist. January 08, 2003) (Emphasis added)

Based upon the above discussion, whether credit is to be allowed is a matter of discretion for the appeals board to weigh in light of the circumstances of a particular case. Allowing the credit in this case would result in disruption or complete destruction of the purpose of permanent disability. Furthermore, the employer's overpayments of temporary disability benefits were due exclusively to its own error, and allowing a credit would deprive the injured worker of approximately a year and a half of disability indemnity. For these reasons, defendant's request for credit for the claimed TD overpayment in the amount of $69,448.94 for the period of March 31, 2017 through May 10, 2018 is denied.

RECOMMENDATION

The undersigned WCJ respectfully recommends that defendant's Petition for Reconsideration, dated April 18, 2022 be denied.

Respectfully submitted,
ROBERT SOMMER
Workers' Compensation Administrative Law Judge
DATED: April 29, 2022