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THE DEFENSE PERSPECTIVE AND OBSERVATIONS OF THE CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION 2011 SUMMER CONVENTION

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2011 SUMMER CONVENTION OF THE CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION JUNE 30 - JULY 3, 2011

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I.

INTRODUCTION

To our clients:

The 2011 Summer Convention of the California Applicants' Attorneys Association occupied most of the Fourth of July weekend, June 30, 2011 through July 3, 2011. We were in attendance, as usual, and the shrill complaints and protestations with respect to the injustice of Senate Bill 899 have now faded so substantially that they barely register as background noise. In fact, the West appears to be becoming wilder than it ever was.

For the most part, the Association appears to now be wholeheartedly embracing the possibilities presented by the changes in rating methodology mandated by Senate Bill 899, almost enthusiastically accepting the AMA Guides as a source of combining multiple body system impairments supplemented by Guzman/Ogilvie increases wherever possible.

A CAAA practice tip points out that under the old rating schedule, many of the impacts caused by a change in lifestyle resulting from injury were subsumed in the assigned disability rating, but because these impacts now involve objective, measurable impairment under the Guides, they can now be separately considered. The Association's rationale for this is derived from the Guides approach to measuring impairment of the whole person.

The asserted purpose of Senate Bill 899 was to introduce predictability into the system; commentators stated that a proper use of the Guides would allow even a non-examining individual familiar with the Guides to determine an injured individual's impairment simply by reviewing the results of the objective medical evaluation.

No more. The only predictability at this time is the fact that the AMA Guides are the starting point for the impairment analysis; things appear to get pretty wide open after that.

Granted, we have not yet heard the final judicial word with respect to the cases having the most significant impacts. The Baker case (sometimes known as the XXYZZ case), relating to the proper date for the commencement of COLA increases in life pension and total disability cases, was recently argued to the California Supreme Court, and a decision is probably expected sometime in the next couple of months. Ogilvie was recently argued to the Court of Appeal, and, again, the decision is expected in a few months. The Court of Appeal denied the writ peremptorily in Almaraz (presumably referencing the prior DCA opinion in Guzman), and the last possible stop in those two cases would be the Supreme Court, assuming the Court elects to hear the cases.

In the meantime, however, especially as it relates to the schedule rebuttals permitted by Guzman and Ogilvie, the Association's consensus is that things are going to remain pretty much as they presently are. Properly used, the defense community can probably live with Guzman. Ogilvie, on the other hand, presents the possibility of too much mischief, and creates the probability of extensive medical-legal expense in the field of vocational evaluation. As a practical matter, in every case where an injured worker has not returned to his usual and customary (or better) work following an injury, an argument for a vocational evaluation under Ogilvie could be made. The fact that the Ogilvie increase is then applied to each individual impairment rating (as opposed to a combined disability rating) certainly creates legitimate concern with respect to when enough is enough. Relatively minor injuries, involving several different body systems (a very common occurrence these days) can result in breathtakingly high ratings with Ogilvie. How is that fair?

The answer, obviously, is that, instead of uniform predictability, each individual case is going to have to be subjected to admittedly subjective standards, and the results are going to vary as widely as the attitudes of the attorneys who litigate them, and the judges who decide them.

With this in mind, let's take a look at some of the more important issues:

II.

COMPENSABLE CONSEQUENCES

The compensable consequence doctrine has been around for many years. Basically, a subsequent injury, incident or condition, which is proximately caused by the original industrial injury arises out of the original injury and is considered a part of it. The seminal case with respect to this doctrine was SCIF v. I.A.C. (Wallin), 24 C.C.C. 302 (1959). Since the compensable consequence arises out of the original injury, with one exception (relating to injuries occurring in vocational rehabilitation, the relevance of which is practically non-existent at this point in time), the subsequent injury is deemed to arise out of the original injury, and a new pleading is not required.

As will be seen, the use of the AMA Guides has significantly broadened the prospects for compensable consequence type claims. Generally, an impairment under the Guides is considered as affecting organ or body system functions resulting in a limitation of common activities of daily living. From this, there may be disability, which the Guides define as an alteration of an individual's capacity to meet personal, social or occupational demands or requirements because of an impairment. That is pretty broad.

We are all familiar with the traditional compensable consequence cases, which were basically accepted without too much consternation: drug addiction from pain medication prescribed in connection with an industrial injury, Ballard v. WCAB, 36 C.C.C. 34 (1971); an injury resulting in instability and causing a fall, The City of Riverside v. WCAB (Norwood), 61 C.C.C. 847 (1996); the effects of medical malpractice in connection with the treatment of an industrial injury, Heaton v. Kerlan, 11 C.C.C. 78 (1946); injuries occurring in connection with attempts to obtain medical treatment, Laines v. WCAB, 40 C.C.C. (1975) (accident on the way to or from a medical appointment), Thrifty Drug Store v. WCAB (Burch), 51 C.C.C. 152 (1986) (an assault in the parking lot of the physical therapy facility) Hutchinson v. WCAB, 54 C.C.C. 124 (1989) (accident on the way to the pharmacy to pick up medication); an accident or injury at the medical facility, even if it does not involve medical negligence, The Emporium v. WCAB (Whitney), 46 C.C.C. 417 (1981).

In connection with these compensable consequence type accidents and injuries, applicant's carelessness or contributory negligence does not break the causative connection, unless the applicant's carelessness or negligence is the sole and exclusive cause of the injury (Beaty v. WCAB, 43 C.C.C. 444 (1978), although even this exception is perhaps a bit broad (for example, if applicant were on her way to a medical appointment, and carelessly ran a red light resulting in an accident, we have no doubt the injuries would still be considered industrial). What the exception actually relates to is the situation wherein the applicant recklessly undertakes a course of action with full knowledge of the risk of injury (applicant sees the red light as she is approaching the intersection, and decides to deliberately run it). Something like this would tend to break the chain of causation.

Essentially, it is a two-prong test: First, was the original industrial injury a contributing factor to the subsequent accident and, if so, did the subsequent accident occur as a result of a rash undertaking of activity with knowledge of the risk created in light of the disability from the industrial injury?

The defense probably still carries a pretty heavy burden.

Even before getting to the AMA Guides, the compensable consequence doctrine produced some pretty insane results, beginning with the landmark case of Wallin (applicant's industrial injury caused double vision and, while cutting up firewood at home, applicant cut off one of his fingers partially because of his double vision; held, compensable). Other examples: applicant was walking, allegedly to exercise, and was hit by a car, Commercial Union Insurance Company v. WCAB (Bender), 57 C.C.C. 2 (1991); applicant, with a back and knee injury, was on the street, and claimed to be unable to jump out of the way of a runaway car, Bailey Plumbing v. WCAB (Walton), 45 C.C.C. 327 (1980); applicant claimed a knee injury decreased his ability to control his personal motorcycle, which resulted in an accident, The City of Oakland v. WCAB (Darby), 45 C.C.C. 363 (1980). Obviously, the system seems to overwhelmingly favor applicant in cases such as this.

The floodgates are really open by the AMA Guides. It is noted that the "whole person" approach in the AMA Guides enables arguments that it is not unusual for the original injury to create one or more medical "compensable consequences" in the applicant, some or all of which may be ratable impairments under the Guides. We think, based on what we are hearing, that we are going to see increasing claims of general "deconditioning", i.e., the inactivity caused by an industrial injury results in weight gain and the development of hypertension and other medical conditions, such as elevated lipids, diabetes, increased inflammation, reflux disease, depression, sleep disturbances, and even death. The argument is that once the "momentum" of deconditioning begins, it is extremely difficult to reverse the process without aggressive medical management, and the number and severity of activity of daily living impacts will continue to increase. Certainly, some of the conditions mentioned do not have their initial cause from the industrial injury, but the employer is going to have responsibility for providing medical treatment necessary to cure or relieve the effects of any related medical condition that is a compensable consequence of the industrial injury (either caused or aggravated). Gardner v. WCAB, 57 C.C.C. 670 (1992).

Some of the conditions which applicants will be attempting to incorporate in their industrial injury will be venous thrombosis (from the effects of inactivity), drug addiction (not a real surprise, given the extent of prescription medication dispensation going on these days); gastric, dental, and heart problems (the effects of medication), obesity (deconditioning); diabetes (aggravation by medication); sleep disturbances; and sexual dysfunction.

As if the combination of these disabilities in conjunction with the original industrial injury is not enough, the Association is arguing that the combined disability table shortchanges the applicant by not taking into consideration the full impact of a combined impairment/disability, in that it tends to reduce the effect of each succeeding impairment. The Association argues that multiple and/or combined disabilities actually have a "synergistic" effect on an applicant, and that even adding the disabilities together is not enough, that there should be some sort of multiplication factor.

We do not doubt that there are cases which warrant substantial (even total) disability ratings, and that the whole story with respect to these cases would probably not accurately be told by simple reference to the various tables in the AMA Guides, and combining them. The problem comes from the attempt to turn the ordinary "whiplash" type case into one of catastrophic disability by attempting to pull in various AMA Guide impairments by way of the compensable consequence doctrine, and then arguing that all of these have a synergistic effect. We see this happening far too often and this is, quite frankly, abuse. It certainly results in a natural cynicism which causes the defense to be suspicious of any case, even the legitimate ones.

A couple of final notes with respect to compensable consequences. Although the effects of an overzealous investigation will be deemed a compensable consequence of an industrial injury (psychiatric injury, for example, Unruh v. Truck Insurance Exchange, 37 C.C.C. 590 (1972); Home Indemnity Company v. WCAB (Bailey), 38 C.C.C. 74 (1973) the so-called "rope jobs"), injury (primarily psychiatric) caused by the litigation process itself is not compensable. Rodriguez v. WCAB, 59 C.C.C. 14 (1994).

One final issue relates to suicides. The defense argument is that suicide is a volitional act, basically a rash and reckless act, which breaks the chain of causation. Perhaps, but the rule seems to have liberalized over the years, migrating from the so-called "irresistible impulse or compulsion" to a more general rule to the effect that the suicide is compensable if it can be shown by competent expert testimony that, in the absence of the industrial injury, there would have been no suicide. See Beauchamp v. WCAB, 33 C.C.C. 112 (1968); Redmond v. WCAB, 38 C.C.C. 805 (1973).

III.

PSYCHIATRIC AND BRAIN INJURIES

One aspect of the new rating system under Senate Bill 899 which remains under some degree of attack is the mandated method of rating psychiatric injuries. Psychiatric injuries are statutorily excluded from rating by way of the AMA Guides, with the mandated method being by way of the Global Assessment of Functioning (GAF). Applicant attorneys continue to argue that there is no scientific validation of this method, and that its members should search for alternatives (although it is our experience that

the GAF method actually results in psychiatric disabilities which rate remarkably close, and sometimes quite a bit more, than the old work function impairments which were used in connection with the 1997 permanent disability schedule).

The Association argues that its members should explore the possibility of alternatives in the AMA Guides (what an about face we have here), in referencing Chapters 14 and 18. However, we think that as long as we are dealing with a strictly psychiatric/emotional type injury, the statutory mandate for use of the GAF is going to apply (although we assume that methods of rebuttal pursuant to Guzman will be available, if it can be shown that the disability rating produced by the GAF is not accurate).

The potential for using other methods to rate what are essentially psychiatric injuries certainly presents itself in connection with brain injuries. We note that there have been some attempts to equate ordinary psychiatric disability with a brain injury, but the consensus at this time appears to require that there be some direct trauma to the brain itself (basically, permanent residuals from any type of head injury would suffice). This is the type of injury which is noted in Labor Code §4662(d) ("an injury to the brain resulting in incurable mental incapacity or insanity"), which is conclusively presumed to be total disability.

While it is acknowledged that brain damage is, in effect, permanent, most brain injuries do not result in this level of disability. Brain injuries are essentially associated with concussions, which literally means a forcible shaking or jolting of the brain. Most mild concussions are not thought to produce permanent cellular damage, and most people who sustain mild traumatic brain injury will fully recover. Interestingly, the mild traumatic brain injury sometimes involves what is believed to be a brief loss of consciousness, although sometimes the only person who believes this is the applicant himself. The reason for this, apparently, is because there is sometimes a period of brief post-traumatic amnesia. Thus, the injured individual can appear fully awake and conscious, and interacting with those around him, and yet remember nothing of this later on (thus, being under the impression that he was unconscious).

The point here, however, is that the brain injury is not a normal psychiatric injury, and that it is thus capable of being rated separately (e.g., utilizing Tables 18-7 and 14-1 in the AMA Guides; Table 18-7 relates to pain related impairment scores, which are said not to be an impairment rating, but which are essentially identical to the impairments due to mental and behavioral disorders set forth in Table 14-1). In fact, some of the panelists contend that there should actually be a combined rating in connection with brain injuries consisting of the psychiatric rating under the GAF, combined with the impairment caused by the neuropsychological deficits (i.e., cognitive impairment), which are considered to be separate and independent from the psychological and emotional impairments. In this regard, reference is made to another Table, Table 13-8, referencing impairments due to emotional and behavioral disorders originating from neurological or other head injuries.

It is argued that the emotional or behavioral effects of a head injury constitute an exception to the threshold criteria for psychiatric injuries (predominant cause, and even the six month rule). To an extent, this is important, because of the cumulative effect of concussions (so, if applicant can be shown to have had a head injury/concussion on a non-industrial basis, there theoretically should be apportionment in the event of a subsequent, industrial concussion).

Issues are going to be created, of course, in connection with "post concussion" symptoms which are really not related to head injury at all. For example, headaches can be caused by muscle contraction in neck injuries, and dizziness can be caused by inner ear injuries. From the defense standpoint, we are going to have to argue that these types of symptoms must be rated differently than a brain injury disability although, of course, we would expect applicant attorneys to argue that the effect of these symptoms makes an analogy argument appropriate.

IV.

FUTURE EARNING CAPACITY ISSUES (OGILVIE)

Senate Bill 899 redefined disability so that its determination must be expressed in terms of lost earning capacity. The landmark case of Argonaut v. I.A.C. (Montana) 27 C.C.C. 130 (1962), defined earning capacity as a prediction of what an employee's

earnings would have been had he not been injured.

Technically, a 100% loss of earning capacity (permanently) should equate to total disability.

This seems to be the gist of a panel decision, Wilkinson v. Ontario Neon Company, ADJ 1107888 (March 25, 2011), where the Board relied upon medical and vocational evidence to the effect that the combination of applicant's disabilities as a practical matter prevented him from working. The panel stated that the 2005 Permanent Disability Schedule itself provides that permanent total disability represents a level of disability at which an employee has sustained a total loss of earning capacity, and also referenced Labor Code §4662, to the effect that in cases other than the specifically delineated ones, permanent disability shall be determined in accordance with the fact. Wilkinson acknowledged that LeBoeuf v. Workers' Compensation Appeals Board, 48 C.C.C. 587 (1983) no longer had direct application to injuries governed by the 2005 Permanent Disability Schedule (noting that LeBoeuf had its genesis in vocational rehabilitation cases), but that LeBoeuf was instructive by analogy, as it supported the concept that where an employee has a total loss of future earning capacity, the employee is permanently totally disabled.

In essence, Labor Code §4662 has replaced LeBoeuf.

The Montana case, which was originally decided in connection with a temporary disability calculation issue, has now found new life in connection with the determination of whether or not there has been an actual loss of future earning capacity as a result of an industrial injury. The so-called "Montana" factors have been given new life in Ogilvie cases, primarily because of the attempts to overreach by applicants in cases such as Shini v. Pacific Coast Autobody, 210 Cal. Wrk. Comp. P.D. LEXIS 21 (2010) and Garcia v. Hinrichson, 210 Cal. Wrk. Comp. P.D. LEXIS 58 (2010) (referenced in our analysis of the 2011 Winter Convention). At least some of the panelists concede the proposition that "bad cases make bad law" and that these are certainly bad cases for attempting to advance an Ogilvie argument.

Thus, in an Ogilvie analysis, the following factors need to be taken into consideration: ability to work; age; health; willingness to work; opportunity to work; skill

and education; general condition of the labor market; and employment opportunities for similarly situated employees. These factors create their own issues. For example, in dealing with an applicant's "ability to work", it is suggested that the vocational expert not base their determinations on "work restrictions", and rather limit their discussions of functional limitations caused by the injury. Quite frankly, this is a very fine line. In Baldridge v. Swinerton, Inc., Case No. ADJ 636377 (July 7, 2010), the Workers' Compensation Appeals Board in a panel decision illustrates just how fine a line (if there is really any line) this is. In this case, the orthopedic whole person impairment was 45%, but the orthopedic Agreed Medical Examiner emphasized that applicant had significant work restrictions and the Board accepted the vocational evaluator's observation that when the orthopedic limitations were viewed in concert with the psychiatric impairment and the vocational factors, "applicant would not present as a viable employment candidate", thus entitling applicant to a 100% award. Certainly, applicant's very significant work restrictions played a role here and are simply being eased back into the system under the guise of limitations on activities of daily living.

Where an applicant is elderly, issues relating into retirement come into play. We might be cynical about this, but we think self-interest will cause many applicants to claim that the only reason they retired was because of the effect of their injuries (no matter how old they are). If a judge believes this (and most of them seem to), then the injury is deemed to be the cause of the retirement (See, City and County of San Francisco v. WCAB (Taylor), 76 C.C.C. 166; Gonzalez v. WCAB, 68 Cal. App. 3d 843 (1998)), and the argument is that applicant is then entitled to future earning capacity adjustment based upon a loss of regular wages.

Health, skill and education are obviously going to present different issues with each individual. With the traditional LeBoeuf case, applicant's preclusion from the labor market had to be the result of the effects of the industrial injury alone. So-called environmental or cultural factors (education, language barriers, for example) would generally not play a role in a LeBoeuf determination.

Applicants' attorneys, however, are arguing that these factors should play a role in the future earning capacity determination. Their support for this proposition comes

from an old Supreme Court decision, Erreca v. Western States Life Insurance Company, 19 Cal. 2d 288 (1942), which, while dealing with a policy of disability insurance, certainly suggests that the concept of disability is different things for different people (i.e., an educated man cannot be expected to enter the physical labor market, while a physical laborer cannot be expected to enter the educated man's labor market). In other words, the analysis with respect to whether there has been a loss of earning capacity is "individualized", an analysis which necessarily needs to take into consideration what would traditionally have been considered non-industrial environmental and cultural factors.

We could probably also expect issues with respect to whether the income generated by the work applicant was doing at the time of injury is a true representation of future earning capacity. These issues have primarily been addressed in connection with permanent disability rates, the primary example being the part-time employee who is in school training for a career. See, Jeffares v. WCAB, 6 Cal. App. 3d 548 (1970), wherein applicant was working as a park recreation instructor at minimum wage, while at the same time going to school working on her teaching credential. In such a case, the applicant's attorneys will argue that the future earning capacity variant should not be based upon the wage being earned at the time of injury, but rather upon what applicant would have expected to earn upon the completion of education.

The defense is likely to focus on the factors relating to willingness and opportunity. Ogilvie may certainly have its place, but it is certainly not for the applicant who prefers being off on disability rather than looking for work (and, sadly, there are a lot of those). Applicants' attorneys tend to equate "opportunity" with employment opportunity similar to those enjoyed by applicant at the time of injury. However, if an injury genuinely precludes an applicant from such an opportunity, that does not equate to no opportunity whatsoever. In fact, the Ogilvie analysis, we think, would be much stronger if applicant demonstrated a motivation to work by hunkering down in a less desirable position and then measured his loss of future earning capacity using that position. It is interesting that most of the litigated Ogilvie analyses which we have seen relate to attempts to show a 100% loss of earning capacity, which suggests to us that

many of the claimed attempts to return to work are half-hearted at best.

We are mindful of the claim that people with disabilities are the last to be hired and the first to be fired. But what kind of message is being sent to employers who hire a person with a significant pre-existing disability, which was requiring significant medical attention, who, after several years, are then faced with a claim that the employment "aggravated" the pre-existing disability, thus saddling the employer with a potentially catastrophic cost of lifetime future medical care? Can the Applicants' Bar realistically expect employers to be willing to take such a gamble?

One last observation relates to the subject of immigration. How is the future earning capacity of an undocumented worker measured? Granted, Labor Code §1171.5 states that a worker's immigration status is irrelevant in determining his right to benefits, but it is certainly relevant in terms of whether or not he can be offered reemployment. In Farmers Brothers Coffee v. WCAB (Ruiz), 133 Cal. App. 3d 533 (2005), the California Court of Appeal held that the federal immigration laws do not preempt California's right to regulate workers' compensation, and the United States Supreme Court seemed to affirm this view in Hoffman Plastic v. NLRB, 535 U.S. 137 (2002), in essence holding that workers' compensation benefits are properly bestowed upon the undocumented worker, with the exception of reinstatement into his prior job, since this would conflict with federal law. Consistent with this view was Del Taco v. WCAB, 65 C.C.C. 342 (2000), holding that an undocumented worker is not entitled to vocational rehabilitation, even if a QIW, assuming the employer was in a position to make a good faith offer of modified work.

By all rights, the employer should be in a position to argue that Ogilvie should not apply to an undocumented worker, since that worker has no legal right to return to work. The response from the Applicant's Bar is that, if the employer knew of the worker's undocumented status at the time of hire (or while he was working prior to injury), then the employer should be equitably estopped from arguing this point.

What all this means, unfortunately, is that the vocational expert is probably going to assume a role which may be similar in importance to that of the doctor. Furthermore, we still have not really addressed the question with respect to how to determine when

multiple seemingly appropriate Ogilvie bumps in connection with a series of minor impairments results in an obscenely excessive rating. That issue will eventually have to be confronted as well.

V.

MEDICAL TREATMENT AND DISABILITY EVALUATION

From the defense standpoint, the most important recent case on the issue of medical treatment is Valdez v. Warehouse Demo Services, 76 C.C.C. 330 (2011), an en banc decision which essentially provides that where an applicant self-procures unauthorized treatment outside of a validly established and properly noticed MPN, the reports of the non-MPN doctors are inadmissible, cannot be relied upon by the trier of fact regarding issues of treatment or disability, and that a defendant is not liable for the cost of services of such non-MPN physicians. This is a significant about-face, since a number of panels had previously held that the only consequence of an applicant self-procuring outside of a validly noticed and established MPN was that a defendant would not be responsible for the cost of medical care (but an applicant could certainly rely upon the reports of these treating physicians for the purpose of establishing rights to disability and medical treatment). In Valdez, however, the Board concluded that Labor Code §4616.6 (which provides, in part, " no additional examination shall be ordered by the Appeals Board and no other report shall be admissible to resolve any controversy arising out of this article") stood for the proposition that non-MPN reports were inadmissible for any purpose. The Board concluded that only a physician selected in accordance with a properly instituted MPN may be considered a primary treating physician.

This is a good case. For years, defendants with valid MPNs had been rankled by applicants' attorneys who routinely yank their clients out of the MPNs and send them to the mills as a matter of general practice. In a recent case in which the undersigned was involved, responding to the judge's question to applicant's attorney as to why she pulled her client out of defendant's MPN, the response was that her firm did not let their clients treat within the MPNs, but routinely pulled them out without regard to the quality of treatment. In another case, a hearing representative for a chiropractic lien claimant

(who mindlessly referred the applicant out to multiple disciplines at the time of the first visit) told the undersigned in no uncertain terms his position that the MPN statutes were completely unenforceable. During the course of the panel discussions, Judge Kahn, as well as several of the commissioners, expressed some recognition that lien claims in the southern part of the state were completely out of control. Perhaps this recognition at the commissioner level was motivation for Valdez.

We understand the concern expressed by one of the panel attorneys for workers involved in disputes with respect to injured body parts, and where, in connection with the disputed body part, a worker might be in dire need of care. The medical practitioner who will provide services on a lien basis certainly has a place here, and the defense might not be so cynical in connection with limited, objective medical care rendered in such a case. Too often, however, the practitioner (as often as not a chiropractor, no matter what the injury) immediately makes multiple referrals for consultations and diagnostics to every specialty imaginable and, when this occurs, it is difficult to fault the defense for feeling that this is not really serious medical treatment.

Similar to Valdez is Scudder v. Verizon California, 39 C.W.C.R. 72 (2011), where applicant was entitled to obtain primary care outside of the MPN because he had pre-designated a physician. He initially began treating with this pre-designated physician, but, when he obtained an attorney, he switched his care to another non-MPN physician, who proceeded to make a referral to an internist, also not within the MPN.

Since the pre-designated physician did not refer applicant to the new free choice physician, or the consulting internist, the Board concluded that neither the free choice orthopedist nor the consulting internist, could be considered treating physicians, and that the reports were inadmissible. The argument was that Rule 9780.1 could be read as permitting such a consultation referral, but the Board declined to interpret the rule in this matter, and stated that, even if that was a correct interpretation, the rule would conflict with the express wording of Labor Code §4600(d)(6), and to that extent would be invalid (citing Boehm & Associates v. WCAB (Lopez), 64 C.C.C. 1350 (1999)).

The panel has referenced a case which is something of an aberration, Leprino Food v. WCAB (Barela), 75 C.C.C. 415 (2010), where applicant went outside of the

workers' compensation system to obtain a spinal surgery which had been nixed by both Utilization Review and the Agreed Medical Examiner, and then received a disability rating based upon the spinal surgery. It is said that this case stands for the proposition that an applicant is entitled to secure his or her own medical treatment at his own expense provided there is good cause shown, but while it is certainly true an applicant can secure medical treatment at his own expense, the suggestion that the medical treatment may play a role in determining an applicant's ultimate disability may no longer be true in light of Valdez.

We think what could become a very significant medical treatment issue in the future is the issue of home care. To a certain extent, this has always been a thorny problem, and is certainly not a form of medical care which defendants are anxious to concede. A fairly recent case touched on the issue, State Farm Insurance v. WCAB (Pearson), 76 C.C.C. 69 (2011). One of the issues was a $1.5 million home care reimbursement award to applicant's spouse for 24 hour a day, 7 day per week care. The award was annulled as the hours logged by the spouse did not equate to 24 hours per day, a number of the services he claimed to be performing (e.g., paying bills), did not appear to qualify as reasonable medical care, and the $30 per hour rate did not appear to be appropriate, since this was the rate which would normally be allowed a licensed vocational nurse.

The panelists did not see Pearson as ruling that certain categories of services (or certain rates of pay, for that matter) were improper as being included in the home care equation, but rather saw Pearson as standing for the proposition that medical evidence was necessary to establish that the rendition of certain types of services to an injured worker were reasonable and necessary as a form of medical care (in other words, if the injury precluded an applicant from paying bills, then that should be a service permitted within the home care equation). The groundwork for this quasi medical concept has been around for many years (California Casualty Indemnity Exchange v. I.A.C. (Elliston), 13 C.C.C. 50 (1948); Pacific Electric v. I.A.C.(Patterson), 15 C.C.C. 88 (i.e., assistance with cooking and cleaning). Medical treatment pursuant to Labor Code §4600 can include professional nurses and personal attendants (Rouseyrol v. W.C.A.B.,

56 C.C.C. 624 (1991); SCIF v. WCAB (Bragan), 48 C.C.C. 538 (1983) (writ denied), and can include reimbursement for spouses or relatives for the care provided (O'Hagen v. WCAB, 56 C.C.C. 708 (1991) (writ denied).

The Association was reminded that the most common opportunity for home care is in the case of surgeries where in almost every case a need for transient home care can be established. The membership was encouraged to either request, or arrange for, professional assessments of what would be required by way of home care, and the members were reminded that significant money can be involved. The panelists contend that spouses and family members cannot be prevented from providing the home care in favor of a professional provider, and to force an applicant to accept a professional would be an invasion of privacy. O'Hagan vs. WCAB, 56 C.C.C. 708 (1991) marital duties do not include extraordinary home care for an injured spouse). Elliott vs. WCAB, 52 C.C.C. (1987) 247; Argonaut vs. WCAB, (Nunez), 72 C.C.C. 1538 (2007) (family member can provide the equivalent of skilled nursing services).

We know for a fact that home care does not become an issue in most cases of surgery, and that family members pitch in to take care of their injured family member until he is up and around. This is done because that is the practical way of doing things. Part of the affordability of the workers' compensation system relates, we think, to the willingness of family to carry some of the burden when necessary (certainly, this is done in the case of non-industrial illness). If reimbursement for the cost of home care is demanded in every case where it is felt there is a real or imagined need for it, suddenly the system becomes extremely expensive, perhaps prohibitively so. Applicants' attorneys should take care that they do not again throw the golden egg-laying goose onto the autopsy table.

We listened with amazement as the panel members spoke in terms of what would happen if the caregiver was injured, with one panel member gleefully announcing that the caregiver would be deemed the employee of the insurance company on the hook for the benefit, and would thus have a workers' compensation case against that insurer. That attitude, of course, is disturbing. The lesson (at least in connection with an applicant's insistence that a family member or friend provide the home care) is that

the carrier should have no direct contact whatsoever with the caregiver and insist that the caregiver invoice their services and bill the applicant directly. Applicant can then be reimbursed. Under those circumstances, if the caregiver is an employee of anyone, it would be the applicant.

We wonder if, under those circumstances, the carrier would be entitled to insist that the applicant carry a policy of workers' compensation?

A case which, on its face, appears somewhat unfavorable, is the en banc decision of Guitron v. State Compensation Insurance Fund, 76 C.C.C. 238 (2011) holding that the requirement of Labor Code §4600 that an employer furnish reasonable medical care includes the provision of an interpreter during the course of medical treatment, including such services as routine chiropractic or physical therapy services.

On the other hand, the case holds that it is the lien claimant's obligation to prove that the services were reasonable and necessary, that they were actually performed, that the interpreter was qualified to perform them, and that the fees charged were reasonable. In fact, the court suggests that since medical treatment services are not within the description set forth in Regulation 9795.3, the minimums (or, even, the allowance of the "market rate") established in that regulation do not apply. In other words, the court felt allowing a two hour minimum for a fifteen minute appointment might not be appropriate, although it acknowledged that some provision for travel time and wait time might have to be made. There is plenty of litigation left in connection with interpreters' liens. In Garcia v. Zurich American Insurance Company, 39 C.W.C.R. 15 (2011), an interpreter's lien was disallowed in a panel decision where it was shown that the chiropractor advertised that he could accommodate Spanish-speaking patients, and he himself spoke Spanish. The surprise here is that the judge actually allowed the lien, although this decision was vacated by the panel on the basis that the services were not necessary. Consistent with Guitron's suggestion that the minimum (whether statutory or the market rate) did not apply, the Board noted that the interpreter did not identify the actual time spent.

Obviously, this is something at which we are going to be looking from now on.

VI.

DISCOVERY, INVESTIGATION, AND FRAUD

We will start with the general proposition that discovery in workers' compensation cases, as in most civil matters, is pretty wide open. Unwarranted interference with the parties' discovery can be sanctionable conduct. See, Cabanilla v WCAB (Rivera), 68 C.C.C. 1375 (2003) (writ denied), which stands for the proposition that, in general, the only reason to be instructing a witness not to answer questions in a deposition is to protect a privilege, or because the question poses some hardship on the witness (which we suspect would probably relate to some sort of personal privilege).

The hot topics with respect to discovery at this time, however, seem to relate to Panel Qualified Medical Examiners, specifically the issue of communications. This issue was thrust to the forefront in Alvarez v. WCAB, 75 C.C.C. 817 (2010), where relatively innocuous communication initiated by the QME to the defense attorney relating to the whereabouts of certain records he was supposed to be reviewing resulted in a finding that this was a prohibited ex parte communication which resulted in the disqualification of the QME, and gave applicant the right to a new panel. An exception was carved out for "incidental communication", but truthfully, no one really seems to know what that is, and attorneys on both sides are jumpy about even contacting QMEs' offices to schedule examinations.

In light of this, the result in State Farm Insurance Company v. WCAB (Pearson), 76 C.C.C. 69 (2011) was probably predictable. This actually involved a medical examiner appointed by the judge pursuant to Labor Code §5701. Without advising the defendant, applicant scheduled the appointment, and apparently withheld some of the medical records. This was held to be a prohibited ex parte communication.

In light of these cases, however, Koenig v. AT&T Mobility, Inc., 39 C.W.C.R. 37 (2010) is out of step. This panel decision (involving a pro per) felt that applicant's contacting the physician six weeks after her evaluation to seek his advice with respect to medical care was a communication which occurred in the course of the examination, a holding which stretches the governing statute way past its breaking point.

We believed, however, that we understood the concept of "ex parte communication" well enough to be certain that the so-called "issue letters" were permissible. Labor Code §4062.3 governs what can be sent to a Qualified Medical Examiner, giving a party the opportunity to object to the transmission of non-medical records (at which time the Board makes the decision as to whether the material can be sent). Regulation 35 implements this statute and also deals with the issue letter, providing that, at least the initial one, must be served on the opposing attorney 20 days prior to the QME evaluation. We assumed that there was no right of objection to the issue letter, since the issue letter was nothing more than a communication from the attorney advising the doctor with respect to the party's position and contentions with respect to the case (it is not an ex parte communication, since a copy was served on the other side). Apparently, there was a panel which disagrees with that. In Ferniza v. Rental Center, Case No. ADJ 1644999 (Dec. 27, 2010), the panel held that, if the other side objects, an attorney cannot send a position statement to a doctor which references both medical and non-medical information, and also seems to imply that medical records, as opposed to the reports actually generated in connection with the case at issue, would be considered non-medical records for the purpose of objection. The panel holds that in the event of an objection, the position letter and non-case related medical records cannot be sent absent an order from the Workers' Compensation Appeals Judge.

One of the panelists indicated that, in light of this decision, a judge prohibited him from sending a doctor a copy of the Benson decision, suggesting the doctor did not need to see that. We find that to be a rather incredible position.

A panel decision from the Workers' Compensation Appeals Board is not stare decises. It is not binding precedent. We can (and will, if we have to) take the position that the decision is just plain wrong, and will argue to judges that they need not follow it. The problem, however, is that many judges view these panel decisions as being indications of how at least a segment of the WCAB commissioners feel about an issue. Thus, there is some consternation and caution with respect to what could be done with the issue letter.

Another significant topic of discussion related to sub rosa. Some of the more enlightened contributors did not see it as the evil invasion of privacy envisioned by most applicants' attorneys, but suggest an understanding that sub rosa exists not to torture the applicant, but rather to crack down upon those who abuse the workers' compensation system. The advice is to emphasize to the applicant to be honest at the time of his deposition and to "tell the truth". Amen. It is noted that disclosure of the film does not have to be made until after applicant's deposition (City of Los Angeles v. WCAB, 59 C.C.C. 1062), but that the film is really only relevant to the case if it changes the opinion of the physician (JT Enterprises v. WCAB (Nikova), 75 C.C.C. 774, which means that the film has to be reviewed by the physician (although, perhaps, this is not necessarily true in connection with a temporary disability issue, where an applicant claims he is not working and the films show that he is not being truthful). Conversely, however, the medical reports of physicians who do not review available sub rosa film may not be considered substantial evidence. M/A Com-Phi v. WCAB, 63 C.C.C. 821 (1998). Generally, the investigator must be available to lay the foundation of the film.

Sub rosa issues most commonly arise at the time of the Mandatory Settlement Conference. Applicants' attorneys take the position that it is not sufficient to simply list the films on the exhibit list at the time of the Mandatory Settlement Conference. They take the position that the films must be disclosed and served well in advance of the MSC, so as to give the attorney, applicant, and physicians an opportunity to review it. They probably have a point here.

Even in connection with film taken after the MSC date, unless a defendant can explain why it was not possible to obtain the film prior to the MSC, it will generally be excluded, as being barred by the closure of discovery. See, Presbyterian Intercommunity Hospital v. WCAB, 62 C.C.C. 1316; San Bernardino Community Hospital v. WCAB, 62 C.C.C. 986. If the defendant can show diligence in attempting to obtain the film prior to the date discovery was closed, it may be allowed. UPS v. WCAB, 64 C.C.C. 369.

Similar to sub rosa is the obtaining of information from various social websites, such as YouTube, Facebook, and Myspace. Applicants' attorneys have genuine

concern with respect to their clients posting items on these networks, as they are capable of being obtained by the defense, and can lead, not only to sub rosa, but used as direct evidence of an applicant's activities. Applicants' attorneys argue that the material is objectionable, since there is no legal foundation, but we think the foundation can probably be established by the applicant's own testimony. When applicants lie about it under oath, they risk a penalty charge.

There are certainly privacy considerations. Even sub rosa is governed by Civil Code Section 1708.8(g) which permits sub rosa where there is an articulable suspicion of misconduct. That is a rather broad standard and, as a practical matter, the bigger the case the more likely there is to be sub rosa. It must be fair, however, and so-called "rope jobs" are specifically prohibited. Redner v. WCAB, 5 Cal. 3d 83 (1971).

On the subject of investigations, an issue relates to the discovery of investigation reports and statements.

We probably do not see eye-to-eye with the Applicant's Bar with respect to the discovery of investigation reports. Many applicants' attorneys believe those to be discoverable (Hardesty v. WCAB, 41 C.C.C. 111). Certain aspects may well be, for example, the time logs recorded in connection with sub rosa, as well as witness statements. Certainly, the investigation reports (which we generally maintain are subject to the work product privilege) are not nearly as ironclad as attorney-client communications, and the court certainly has the discretion to order disclosure if it feels that non-disclosure would not be fair or equitable Suezaki v. Superior Court, 58 Cal. 2d 166 (1962). The attorney-client privilege is absolute, but it can be waived, and, once waived, it is then open to discovery. Lamouree v. WCAB, 70 C.C.C. 640 (2005).

The problem with not disclosing statements, of course, is that an applicant can prevent the witnesses from testifying at the time of trial (City of Livingston v. WCAB (Madrid), 69 C.C.C. 556 (2004), a real inconvenience if the testimony of those witnesses is critical on an issue such as injury AOE/COE. If an investigator takes the statements, the answer to the question of whether they should be served is relatively easy: in almost all circumstances, they should be. A more delicate question occurs when the defense attorney conducts witness interviews in preparation for trial and

prepares summaries of what the witnesses say. Is this discoverable? A fairly recent case, Coito v. Superior Court, 182 Cal. App. 4th 758 (2010), has held the statements of a witness taken by an attorney or an attorney's representative, which do not contain the attorney's impressions, conclusions, opinions, or legal research theories, are discoverable. An appeal with respect to this decision is apparently pending with the Supreme Court.

For the most part, the discovery and investigation serves to assist the employer in defending the claim. Occasionally, it reveals information which warrants more drastic action, which is a fraud referral (and it is important to realize that applicants are not the only ones subject to the workers' compensation fraud statutes; carriers and employers are as well).

The California Department of Insurance has issued guidelines and protocols for workers' compensation insurance special investigation units, updated as of March, 2011. This document defines workers' compensation abuse as any practice that uses the workers' compensation system in a way which is contrary to its intended purpose, and that abuse can include fraud which occurs when someone knowingly lies to obtain some benefit or advantage to which they are otherwise not entitled. A carrier is mandated to report information to the proper authorities if it has a reasonable belief that fraud has been committed. It should be noted that this representation is material if it can influence a determination, even if the misrepresentation does not cause the target to take action. People v. Gillard, 57 Cal. App. 4th 136 (1997).

In connection with a civil action, an applicant's conviction of criminal misconduct in connection with a claim for workers' compensation benefits can have different effects on his ability to obtain those benefits. It should be noted that an applicant is only disqualified from obtaining workers' compensation benefits if he is convicted of violating Insurance Code Section 1871.4 or Penal Code Section 550 (which are the actual insurance fraud sections). Conviction of other penal statutes relating to theft or attempted theft will not result in an automatic disqualification. Berkeley Forge and Tool v. WCAB, 71 C.C.C. 415 (2006) (writ denied).

VII.

SANCTIONS

This is a highly unpleasant topic. Since the Workers' Compensation Appeals Board commissioners on hand made it known that their office was understaffed and overworked, that their patience was running somewhat thin, and that they would be considering more of them, this may be a timely topic.

In the spirit of the commissioners' comments, we note the panel decision in Vadnais v. Kraft Foods Nabisco, Case Nos. ADJ 2073289; 2667420 (May 27, 2011). In this case the defendant did something which is not too infrequently seen, especially in light of Benson. Essentially, in a case involving multiple industrial injuries, the defendant over-advanced one of the cases, so it simply shifted the overpaid advances to the under-advanced second injury. Legally, a defendant cannot do this, as payments made in connection with one injury cannot be credited against a legally separate injury. Doing this unilaterally without Board approval earned the defendant a $2,500.00 sanction.

On the other hand, in appropriate cases, the Board will apply principles of equity to prevent unjust enrichment if the defendant's conduct in over-advancing was innocent (although the case did not go into detail, it appears the defendant treated the two injuries here as combined under the old Wilkinson case, and paid all of its advances on a master file; when Benson was decided, suddenly the two injuries were separated, and advances had only been made on the master file, which resulted in an over-advance).

Now, here is where the Commissioners' patience ran thin. In exercising equity, and ordering that the overpaid advances be credited against the second injury, the judge made a mathematical error, and shorted the defendant by three cents. Defendant petitioned for reconsideration over this three cent shortage, and the Board was not amused, stating that "to waste the Appeals Board time and resources over a three cent error does an outrageous service....". An order to show cause with respect to a second sanction issued.

The lesson here: Don't sweat the small stuff.

The statutory and regulatory provisions relating to sanctions are Labor Code §5813 (bad faith actions or tactics that are frivolous or solely intended to cause unnecessary delay) and 8 C.C.R. §10561 (setting forth the procedure for imposing sanctions, and providing a laundry list of questionable conduct which could form the basis for a sanction award). The decision with respect to whether or not to award sanctions essentially tracks the civil sanction statutes, and the general purpose is to control burdensome and unnecessary legal tactics. Hershewe v. WCAB, 67 C.C.C. 1198 (2002).

From a defendant's standpoint, a somewhat chilling case (which was the subject of a summary denial of reconsideration) was Alvarez v. Moreno Valley Unified School District, ADJ 6411834; 6436880; 6411835 (reconsideration denied August 25, 2010). This case involved a relatively common issue: A dispute with respect to what constitutes a reasonable hourly rate for Labor Code §5710 deposition fees. In this case, applicant's attorney requested $275.00 an hour, to which defendant objected, and paid $250.00 per hour. A judge granted applicant attorney's petition at $275.00 per hour (with the standard provision giving the defendant an opportunity to object), and the defendant objected. Applicant pushed the case to trial on this issue, then requested costs and attorneys' fees under Labor Code §5813.

The case appears to stand for the proposition that pretty much everything about a Labor Code §5710 deposition fee is discretionary with the trial judge, including the hourly rate. The trial judge noted that there is no uniformity or guideline with respect to the hourly rate, so that it was up to the judge's discretion and, if the defendant objected to the rate ordered by the judge, the defendant was required to produce competent evidence that the rate was unreasonable (the judge indicated that evidence establishing that other judges were awarding a lesser rate was not necessarily considered to be persuasive). Since the defendant did not do that in this case, attorneys' fees and costs in the amount of $2,250.00 were awarded, and, on reconsideration, the defendant was admonished that it was lucky further sanctions were not imposed for the reconsideration.

While this case did not involve a terribly excessive hourly rate, we have been concerned in the past with respect to some of the deposition fee petitions we have seen that they are not scrutinized by the judges who seem to routinely sign them. We become especially concerned about this when we see, in addition to the standard preparation and deposition time (and travel time, if necessary) items such as reviewing the file prior to preparing the applicant; reviewing the deposition transcript after completion of the deposition; a conference with the client regarding deposition corrections, etc. Are these truly considered discretionary items as well, as the statute is not terribly clear on what is included in connection with services rendered in a deposition?

From a defense standpoint, we have always felt that the sanction statutes were used much too sparingly with respect to lien claimants. One of the most frustrating aspects of the practice is dealing with lien claimants at the conclusion of the case in chief. The problem, of course, is Labor Code §4903.5, which provides an outside statute of limitations for the filing of the lien of five years from date of injury (and by many judges, even this statute of limitations is observed primarily in the breach). Thus, most judges take the position at a lien conference that, no matter what kind of notice has been served on the lien claimant, if a lien claimant's lien has not been filed with the Workers' Compensation Appeals Board, the judge will refuse to take any action with respect to it (or any type of punitive action with respect to the lien claimant when they eventually get around to filing their lien and scheduling the fourth or fifth or sixth lien conference on the case).

Regulation 10240 defines when appearances are required, including those of lien claimants, but the problem is that a lien claimant is not considered to be a party until it gets around to filing its lien.

A noteworthy case, which may prove to be useful, is Escamilla v. WCAB (Crumpton), 73 C.C.C. 280 (2008), wherein the lien claimant was sanctioned for attempting to relitigate a resolved lien. Perhaps this rationale might be applied to situations where lien claimants insist on requesting hearings where the case in chief has either been resolved against the applicant (a take nothing), or where similar issues were

resolved at a lien trial which the lien claimant chose not to attend.

In general, it does not appear that the sanction statutes are meant to apply to situations where defendant has denied liability in a case, as long as the defendant has not acted with an "improper motive" or used frivolous delaying tactics. Blades v. WCAB, 69 C.C.C. 1021 (2004).

Finally, as an aside, we note the case of Coca-Cola Enterprises v. WCAB (Espinoza), 76 C.C.C. 391 (2011), referencing the method by which a penalty on paying the improper temporary disability rate is to be calculated. Despite Regulation 10101.1, which applicants attempt to argue requires the payment of a maximum temporary disability rate prior to the furnishing of a wage statement, the court held it was improper to base a penalty on the difference between what was actually paid, and the maximum temporary disability rate, where applicant's actual temporary disability rate was less.

VIII.

OTHER ISSUES

(A) Permanent Disability.

We suppose a question at this point is whether the Supreme Court is going to do anything further with Almaraz/Guzman (the Court of Appeal denied the writ in Almaraz and the petition for review has not been filed with the Supreme Court). A case very similar to Guzman was the panel decision in Laury v. SCIF, 39 C.W.C.R. 67 (2011), where a doctor decided that neither the range of motion nor DRE methods accurately described the extent of applicant's spinal impairment. Instead, he explained that his clinical evaluation demonstrated that applicant had lost 60% of the use of his spine, and applied that percentage to the whole person impairment for a complete spinal impairment (90%), to come up with a functional capacity loss of 54%. As this was an analogy within the four corners of the Guides, it was permitted.

On the other hand, in Lopez v. WCAB, 76 C.C.C. 180 (2011) (writ denied), a measurement with respect to applicant's grip loss was excluded from the rating determination, where the physician did not indicate that applicant's range of motion testing did not accurately describe applicant's impairment.

(B) Apportionment.

We are not sure that Southern California Gas Company v. WCAB (Vazquez), 76 C.C.C. 276 (2011) (writ denied) breaks any new ground, but it was interesting for the proposition that a defendant was unable to challenge the opinion of an Agreed Medical Examiner to the effect that the disability from two separate industrial injuries were so intertwined that any attempt to separate the disabilities as between those injuries would be speculation. The opinion was not so surprising as was the Agreed Medical Examiner's expression of opinion in his reporting that he disagreed with the Benson decision on apportionment as between industrial injuries. The defendant attempted to show some bias from this but, despite this expression of personal opinion by the doctor, the Board found his opinion on the apportionment issue to be substantial, and upheld it.

(C) Procedure.

Lest we forget, jurisdiction of the Workers' Compensation Appeals Board is only invoked by the filing of an Application for Adjudication of Claim, which is then assigned an ADJ number, and not by the pre-application assignment of an EAMS number (which generally appears on the summary rating determination performed by the Disability Evaluation Unit in connection with a pro per case). We assume, however, that the Board is certainly granted jurisdiction when the ADJ number is assigned at the time settlement documents are filed in a pro per case (either a Stipulation with Request for Award or a Compromise and Release).

Speaking of EAMS, a rather interesting case illustrating the headaches of this system was Hernandez v. AMS Staff Leasing, 76 C.C.C. 343, (2011), where defendant filed a petition for reconsideration and/or removal in connection with a discovery order against it. It appears the WCAB file had not been scanned into the EAMS system, so none of the underlying documents referenced in the petition for reconsideration were available to the WCAB (and their problem was compounded by the fact that the case was eventually Compromised and Released, and no one bothered to tell them about it; the Compromise and Release was apparently not scanned into the system timely either). The Board acknowledged that there were very real problems causing system-wide backlogs related to EAMS, but that these problems did not excuse the failure by

the parties or the judge from insuring that a complete and properly organized file was sent to the WCAB.

How does one ensure this? We hear the commissioners still do not want documents attached to the petition for reconsideration, so we think the only realistic method of complying by this request is waiting for the Workers' Compensation Appeals Board to advise either the judge or the parties that it is missing the documents relevant to the decision.

(D) Petitions to Reopen.

We normally do not like referencing unpublished Court of Appeal decisions, since they are uncitable, but there are two rather interesting ones on this subject which should be noted for their rationale. First, is California Highway Patrol v. WCAB (Griffith), 75 C.C.C. 1241 (2010), where a stipulated award issued in connection with a highway patrol officer's cumulative trauma to his back, neck, head, right hand, gastrointestinal, headaches, bilateral knees, feet, and right hip. He then filed a petition to reopen adding additional body parts which included the left thumb and left trigger finger, as well as his heart. He was allowed to do this on the ground that these new body parts involved the same theory of injury, a cumulative trauma, and that there was, therefore, a nexus between the original claim and the new body parts. The Workers' Compensation Appeals Board concluded that since the disabilities to the hand and heart were not known at the time of the original stipulated award, he could do this.

The court noted that there were actually two statutes involved, Labor Code §5410 relating to new and further disability, and Labor Code §5803 which gives the Board continuing jurisdiction, within five years of date of injury, over all of its decisions allowing rescission, alteration or amendment of the decision on a showing of good cause. It was noted that this was not really a case of new and further disability, so Labor Code §5410 did not apply, however, Labor Code §5803 did apply, since applicant showed good cause with respect to the development of disability regarding his left hand and heart.

The Association thinks State Compensation Insurance Fund v. WCAB (Hancock), 75 C.C.C. 1336 (2010) is in conflict with Griffith, but we do not think so. In

Hancock, applicant received a stipulated award for a cumulative injury for the low back, bilateral knees, and bilateral carpal tunnel (wrists). Applicant then filed a petition to reopen alleging new body parts, the bilateral shoulders. In this case, applicant was not allowed to reopen the case under either Labor Code §5410 or 5803, primarily because the shoulder condition was manifested in the medical records which were generated prior to the original stipulated award. It was noted that applicant had complained about pain in his shoulders to the medical examiners, as well as commenting that he thought his shoulder condition was caused by the original cumulative injury. Since the shoulder condition was known at the time of the original Stipulation with Request for Award, he could not establish good cause.

This is the critical difference between Griffith and Hancock: In Griffith, applicant had no knowledge with respect to the disability in the new body parts; in Hancock, applicant did.

IX.

CONCLUSION

One of the panelists commented that the workers' compensation practice is becoming as complex as civil litigation. We do note that, with the development of what is required under Ogilvie, it appears vocational experts are going to become as prominent in this practice as physicians (we note the Administrative Director is contemplating a vocational fee schedule at this time). It will be increasingly difficult to predict the value of cases beyond determining the basic whole person impairment. Our original comment with respect to the problems worked by Ogilvie related to the fact that an Ogilvie adjustment could be applied to any whole person impairment, and there was no clear guidance with respect to when or if that would be appropriate, even if a loss of future earning capacity inconsistent with the standard FEC adjustment was established. It would be one thing if the Ogilvie adjustment was allowed with respect to an overall, combined rating, but the fact that the adjustment is applied to the whole person impairment with respect to each body system creates the possibility of ridiculously high ratings.

The language of the case suggests the trial judge still has some discretion to determine what is and what is not reasonable, so we will just have to see if the judges exercise that discretion.

Several conventions ago, we noted the observation of the claims manager who, in connection with the case regarding the commencement date of COLA increases commented that, in his view, claims were simply going to become more expensive. Nothing has happened in the interval to suggest that he was incorrect, and it appeared to us that one of the underlying themes of this convention was maximizing benefits, the flip side of which is simply making claims much more expensive. We seem to be rapidly heading down that road where there will again be loud cries for reform.

Legislatively, it does not appear that anything significant is on the horizon. We rather doubt that there is going to be anything done to restrict an applicant's access to benefits, and the amounts, in the near future. There may be some restriction with respect to lien claims, at least in the south, as a result of the Valdez decision, and that, at least, is a good thing.

If you have any questions or comments, or would like us to make a presentation based upon these materials, or any subject in which you may have an interest, please advise, and we will be more than happy to assist.

Very truly yours,

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