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

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2011 WINTER CONVENTION OF THE CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION JANUARY 20-23, 2011

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I.

INTRODUCTION

To our clients:

We were in attendance at the 2011 Winter Convention of the California Applicant's Attorneys Association held January 20, through 23, 2011 in San Diego, California. The convention was of particular interest, since it came on the heels of a change of administration in Sacramento. The 2004 reforms which were embodied in Senate Bill 899, and bitterly detested by the Applicant's Bar, were the brainchild of former Governor Schwarzenegger, who is viewed as no friend of the injured worker. Governor Brown is viewed as being friendly and sympathetic, so we would have thought there would have been some concrete proposal directed to the unraveling of Senate Bill 899 which would have been given a fair amount of attention at this convention. Not so. We were actually mildly surprised at the relative lack of concrete proposals made during the legislative session with respect to workers' compensation issues.

There may be several reasons for this. First, as one of the panelists commented, the governor and legislature presently have their hands full with a budget in crisis; workers' compensation is not one of their priorities at this point. Secondly, as has become apparent during the last several conventions, applicant's attorneys, despite continuing to complain (they have always complained, even for years before Senate Bill 899), have learned to work with the system and, especially with the trends toward allowing rebuttal of the AMA Guides in appropriate circumstances (as well as the fact that many physicians tend to inflate their AMA Guides evaluations even without reference to a rebuttal), the focus is now on what most pre-SB899 conventions were about: Maximizing benefits.

The most hated aspect of SB899 relates to the new apportionment rules and we have legislative panelists vowing to introduce legislation to eliminate apportionment based upon so called "cultural factors" (age, sex, race). If attempts at apportionment were based simply upon those factors, there would be no need for legislation, since anti-discrimination laws are already in place. What the Association really wants are rules precluding apportionment to certain types of pathology and actual disability which are commonly associated with these so called cultural factors (i.e., degenerative changes with age; osteoporosis with women; hypertension with African Americans). Of course, it is interesting that nobody really mentions the fact that the Permanent Disability Rating Schedule (this one, and all the ones before it) have always "discriminated" on the basis of age: The older that you are, the higher your rating, and the more benefits you receive. Unlike the apportionment, which is the object of the Association's complaints (since the apportionment is to an actual physical condition), the schedule's adjustments are purely age based.

This being one of the major focuses of the legislative panel, the presentations were focused on stories of discrimination and unfairness, particularly in employment settings. To be clear, if an employer locks its restrooms and forces its employees to request the restroom key from management simply because the employees are "Mexican", and they are believed not to be able to keep the restroom clean, then this is an employer which needs to be sanctioned. We would submit, however, the vast majority of employers are not like this. To rally up the troops with implications that this type of thing is commonplace and goes on all the time appears to us to be something of a disservice. It demonizes employers, which is no more necessary than demonizing workers' compensation applicant's (there are abusive ones, for sure, but most of them are hurt). The fact of the matter is that, without employers, there are no employees (just as the converse is true: Without employees, there are no employers). We all depend on each other, so weed out the bad ones on both sides, but otherwise show some respect.

By now, we are all aware that the 6th Appellate District of the Court of Appeals has affirmed the Workers' Compensation Appeals Board's en banc opinion in Guzman. Milpitas Unified School District v. WCAB (Guzman III), 75 C.C.C. 873 (2010). The 6th Appellate District is apparently picking up a bit of a reputation as being the liberal standard bearer on the workers' compensation benefit front (this was the District responsible for the Duncan decision in connection with the commencement date of the COLA adjustment, which is still presently pending before the California Supreme Court). A petition for writ of review to the California Supreme Court with respect to Guzman was denied on November 10, 2010, so Guzman is final.

That does not necessarily mean it is the last word. Petitions for writ of review are pending in the 5th Appellate District with respect to Almaraz v. Environmental Recovery Services (the other half of Almaraz/Guzman), 74 C.C.C. 1084 (2009) and in front of the 1st District with respect to Ogilvie v. City and County of San Francisco, 74 C.C.C. 1127 (2009) (it appears as Writ in Ogilvie has been granted). A Obviously, there is still the possibility for some change regarding methods of rebuttal. Interestingly, although it was not mentioned during the legislative panel, there was a suggestion in the syllabus materials that, in connection with the adoption of the new Permanent Disability Schedule (or, even, in connection with a compromise on apportionment), Ogilvie may be legislatively eliminated.

Simply for reference, the 3rd Appellate District of the Court of Appeal has taken issue with the 6th Appellate District in connection with the interpretation of the COLA commencement date in Allied Waste Industries, Inc. v. WCAB, 75 C.C.C. ____ (2010). The 3rd District takes the position that the COLA adjustment begins on January 1 following the date of injury (which was the original position taken by the applicant in Duncan; Duncan adopted CAAA's position that the COLA adjustment for any date of injury subsequent to January 1, 2003, began retroactively back to January 1, 2004, which leads to some pretty absurd financial results). The Allied opinion is unpublished, probably in

deference to the Supreme Court's consideration of Duncan, but we would not be surprised at this point to see the Supreme Court grant review in the Allied case as well.

II.

REBUTTING THE SCHEDULE, PART IV

The ability to rebut the Permanent Disability Rating Schedule is the factor which has calmed the intense hostility which the Applicant's Bar previously harbored against SB899. There were certainly suggestions in appellate decisions dating back almost to the adoption of Senate Bill 899 that the schedule was rebuttable, given the appropriate facts and circumstances, but the issue was blown wide open with the Almaraz/Guzman/Ogilvie line of cases.

Almaraz/Guzman (and now, with the affirmation by the Court of Appeal in Milpitas Unified School District v. WCAB (Guzman), 75 C.C.C. 837 (2010), would probably be considered the most traditional approach to rebutting the schedule, dealing with the evaluation of the actual impairment/disability itself. To a certain extent, Almaraz/Guzman was inevitable, and was a logical reaction to the circumstance where a strict application of the AMA Guides resulted in a zero rating where an applicant had an obvious injury and disability. In Hyatt Regency Hotel v. WCAB (Foote), 73 C.C.C. 524 (2008), the court held that allowing a zero disability rating for a worker who had functional disability actually contradicted the instructions in the first two chapters of the AMA Guides to the effect that a worker's condition must be adequately and specifically considered by the AMA Guides. This certainly seems to support the contention that a "zero" WPI rating would not be valid if there are physical functional consequences or activity limitations as the result of an industrial accident. Since a strict application of the tables in the Guides allowed such a result, it was only a matter of time before the court stepped in.

Part of this process was to rein in the rater. The Disability Evaluation Unit assumed that it was its function to determine the sufficiency of the physicians' opinions relating to AMA impairments in relation to the instructions regarding application of the impairment tables. The raters would do this at times in the face of contrary instructions from the trial judge (see, for example, Guzman, where the rater took the position that the Guides did not permit the Agreed Medical Examiner to determine WPI from functional capacity loss, even though the trial judge instructed the rater to consider this).

This type of circumstance led to the Workers' Compensation Appeals Board's decision in Blackledge v. Bank of America, 75 C.C.C. 613 (2010) (en banc), which essentially defined the roles of the various critical participants in the computation of a rating (physician, trial judge, and rater). In brief, the physician's role was to assess the whole person impairment by a report setting forth facts and reasoning supported by substantial evidence; the judge's role was to frame instructions to the rater based on substantial evidence (and even with respect to the rater's opinion as to what should or should not be rated), and the rater's function was to issue a recommended rating based solely upon what he or she was requested to do by the judge (in essence, the rater is an expert witness, and not a fact finder). Even after the issuance of a recommended rating, the judge is not bound, and as the fact finder, has the authority to independently rate an employee's permanent disability.

The most significant limitation on this method of rebutting the schedule is that the physician may not go outside the four corners of the AMA Guides in determining an applicant's whole person impairment, although he may use any chapter, table, or method in the AMA Guides that most accurately reflects the applicant's impairment (Guzman, Blackledge). Blackledge notes that where an employee's medical condition impairs his ability to perform activities of daily living in the same or similar manner as another medical condition, it may be appropriate for the physician to utilize the WPI for that other medical condition by analogy.

The contention, therefore, is that every whole person impairment evaluation involves at least three chapters in the Guides, Chapters 1 and 2 (the general approach instructions), and then the specific chapter which sets forth the impairment. Logically, the argument is that if the applicable table cannot accurately produce an appropriate whole person impairment, a rating that uses the methodology of another table within the same chapter would appear to be the next logical progression in the analysis. More controversial is the proposition that, in the rare event that rating accuracy cannot be achieved within the chapter relating to the specific body region, other chapters may be utilized.

The danger from our standpoint is to assume that Almaraz/Guzman variations are an accepted method of rating every case. They are not; they are rebuttals. In every case, the scheduled rating, reached by using the table appropriate to body region and disability, and evaluated in accordance with the instructions provided for that table, is the presumably correct rating (that is the defense contention, anyway). We think every analysis of an applicant's disability must start with this rating (although, admittedly, Guzman III may actually give some support to the argument that the rating analysis does not really have to start here, based on the statement in that case that a physician's "failure to follow all of the instructions in the first two chapters [in applying the tables contained in the succeeding chapters] could result in useless evidence").

The real key for the physician is to explain the "how and why". Mere conclusionary statements that a variation to the Guides' direction is reasonable, without explaining alternatives or methods are not considered substantial evidence (see, Lorenz v. Stowasser Pontiac, 2010 Cal. Wrk. Comp. P.D. Lexis ____. In Cortez v. Zurich North America, 36 C.W.C.R. 41 (2007) and Hyatt Regency Hotel v. WCAB (Foote), 73 C.C.C. 524 (2008), the physicians explained why they felt variations to the strict instructions of the Guides were necessary in order to obtain accurate ratings, and these decisions were upheld.

As noted previously, the most controversial method of applying the Guzman exception is the use of chapters which do not relate to the body region in question (but may relate to similar symptomology, for example, using the hernia section to obtain a rating with respect to a back or arm injury, based on the argument that the activity limitations set forth in the hernia section are similar to the activity limitations caused by the underlying orthopedic injury). While Guzman technically allows this, we think these situations should be exceedingly rare. Guzman does reference the potential problem of a physician conducting a "fishing expedition" through the Guides "simply to achieve a desired result". The court stated that an impairment rating which is inadequately supported by evidence and reasoning, "and unquestionably, a rebuttal position arrived at by hunting through the Guides for a more favorable rating" will necessarily be rejected as being supported by insufficient evidence. The court stated that "a physician's medical opinion that parts unreasonably from a strict application of the Guides can be challenged," would not be acceptable as substantial evidence. The court also noted that "if the physician expresses the opinion that the chapter applicable to a particular kind of injury does not describe the employee's injury, but all other chapters address completely different biological systems or body parts, it would likely be difficult to demonstrate that that alternative chapter supplies substantial, relevant evidence of an alternative WPI rating."

We read this as significantly limiting a physician's ability to go beyond the chapter specifically applicable to the body part in question.

With respect to the Ogilvie future earning capacity rebuttal (Ogilvie v. City and County of San Francisco, 74 C.C.C. 1127 (2009), although the case has been followed in a somewhat circumscribed manner by the trial courts, the fate of this case is still in something of a limbo, as it has not yet completed its way through the appellate process. In fact, the 3rd District Court of Appeal has granted peremptory writ of review in a case involving similar issues, Zorica Ilic v. Stanford. In that case, applicant was found to have

no post-injury earning capacity, although she supplied no documentation establishing that she had not worked post-injury (or, more importantly, that she could not work), and there was evidence that she had actually helped in the family real estate business, which was generating income. This, of course, is the type of abuse to which Ogilvie-type cases are so easily susceptible. It is this type of nonsense (mechanical application of the Ogilvie formula without any real consideration of the underlying circumstances) that has led to panel reversals of underlying trial decisions with essential directions that the factors set forth in Argonaut v. IAC (Montana), 27 C.C.C. 130 (1962) needed to be considered. See, for example, Shini v. Pacific Coast Auto Body, 210 Cal. Wrk. Comp. P.D. Lexis 21 (2010); Garcia v. Hinrichson, 210 Cal. Wrk. Comp. P.D. Lexis 58 (2010); Ochoa, 210 Cal. Wrk. Comp. P.D. Lexis 59 (2010); Cortez v. Fru-Con, 210 Cal. Wrk. Comp. P.D. Lexis 91 (2010); and Lyon v. Southern California Gas Company, 2010 Cal. Wrk. Comp. P.D. Lexis 425 (2010).

Applicant's attorneys argue that the Montana analysis should be limited, since Montana related to the setting of a temporary disability rate, rather than consideration of diminished future earning capacity factors. They criticized the reasoning on a number of grounds, for example, stating that age considerations violate the analysis set forth in Vaira v. WCAB, 72 C.C.C. 1586 (2007), which states it is impermissible to apportion on the basis of age (wrong on two grounds, the first being that Vaira is unpublished and uncitable, and the second being that the Ogilvie analysis has nothing to do with apportionment; it deals with the realities of the labor market).

The most pertinent statement regarding this issue was probably in the Lyon case, where it was stated that the medical evidence did not support a finding that applicant was completely incapable of working. What these cases are talking about is the fact that someone "hasn't worked" is not equivalent to "unable to work" (referencing Mr. Young's

article in the syllabus). He accurately notes that the real question here is whether the applicant "can't work", or "won't work".

The final type of rebuttal is one which has been around for a fairly long time, and that is essentially the type of rebuttal which is embodied in Labor Code §4662, relating to permanent total disability. Four specific types of disability are specified (loss of both eyes, or sight; loss of both hands or use; practically total paralysis; brain injury resulting in incurable insanity) with a caveat that "in all other cases, permanent total disability shall be determined in accordance with the facts." With respect to the caveat, the most well-known method of rebuttal had its genesis in LeBoeuf v. WCAB, 48 C.C.C. 587 (1983). It does appear that the Workers' Compensation Appeals Board may be conceding that LeBoeuf does not apply to cases in which the 2005 Permanent Disability Rating Schedule is used, but it may still have application relating to cases decided under Labor Code §4662 (since that is not a part of the Rating Schedule, but rather appears to be a statutory exception to it). Thus, Gross v. Slater Brothers Markets, 2010 Cal. Wrk. Comp. P.D. Lexis 360 (2010), noted the trial judge was correct in his ruling that LeBoeuf does not apply to permanent disability when permanent disability is evaluated using the 2005 Permanent Disability Rating Schedule, but suggested that where there is a total loss of earning capacity, that would represent permanent total disability as described on page 1-2 of the schedule. In Baldridge v. Swinerton, Case No. ADJ636377, a 2010 panel decision, the trial judge found a total loss of earning capacity, and thus permanent total disability, in a case where the combined orthopedic and psychiatric disabilities fell well short of 100% using a rating string. A Petition for Writ of Review is presently pending with respect to this case in the 6th District Court of Appeal (which, again, takes a more liberal view of these things). There does seem to be some uncertainty with respect to whether the open labor market plays any role at all, with seemingly conflicting panel decisions in Olejnicznak v. Airport Chevron, 2010 Cal. Wrk. Comp. P.D. Lexis 198, where the Board refused to consider the reporting

physician's use of the "unable to compete in the open labor market" framework at all in connection with the earning capacity issue, and Perez v. Universal Care, Inc., 2008 Cal. Wrk. Comp. P.D. Lexis 524, where a 100% Award was upheld, equating an inability to compete in the open labor market with total loss of earning capacity.

Applicant's attorneys are attempting to argue that a total loss of earning capacity is not necessarily required in a Labor Code §4662 case. They argue Labor Code §4662 does not say "totally diminished earning capacity according to fact", but rather simply that permanent total disability shall be determined according to fact. They continue to argue (as they have for some years) that permanent total disability should be equated with a finding of total disability under the Social Security Disability system, with the true issue being whether an applicant is capable of engaging in substantial gainful activity (noting that the Social Security system does not consider generating an income of less than $1,000.00 a month to be substantial gainful activity).

So far, we have not seen the Board addressing this particular issue. It is probably only a matter of time.

III.

NON-ORTHOPEDIC CLAIMS

Apart from those cases which involve a direct internal medicine-type injury (e.g., the heart attack on the job), the other method of boosting the permanent disability rating is by tacking on various compensable consequence claims, most commonly in the area of internal medicine and psychiatry. Under the 2005 Permanent Disability Rating Schedule, psychiatric disability is not measured by reference to the AMA Guides, but rather to the Global Assessment of Functioning scale. Claimed cardiac and hypertension disabilities are evaluated by reference to Chapters 3 and 4 of the AMA Guides. The interesting thing about hypertension is that it produces ratable impairment under the Guides even without symptoms or functional loss. It is rated by reference to blood pressure and the number of medications needed to control the blood pressure (AMA Guides, Table 4-3).

Impairments with respect to heart disease are generally based upon symptoms and loss of function.

In connection with orthopedic injuries, it is claimed that deconditioning as a result of the orthopedic injury leads to these other, non-orthopedic impairments. It is suggested that under the old rating schedule, many of these impacts were subsumed in the assigned disability rating (essentially, the work restrictions), but under the new system, any objective impacts (whether orthopedic or not) must be shown to have measurable impairments under the AMA Guides rating approach. For example, following a significant orthopedic injury, a worker becomes relatively sedentary, and experiences significant weight gain, or other consequences, which could cause or aggravate hypertension, contribute to abnormal cholesterol levels, and cause stress. It is argued that once the momentum of deconditioning begins, it is difficult to reverse that process without aggressive medical management.

It is also urged that, especially in light of Guzman, there is an alternative method for rating pain, other than the 3% approach contained in Chapter 18 (and as limited in the Permanent Disability Rating Schedule). This relates to the assessment of pain's interference with functional activities. Table 18-7 of the Guides is entitled "Determining Impairment Class on the Basis of Total Pain-Related Impairment Score", and the table provides for a series of "total pain-related impairment scores" ranging from 0 to 80 (no significant impairment to severe impairment), even though there is a note that "the impairment rating score is not an impairment rating".

Applicant's attorneys point out, however, that the pain-related impairment score is identical to the "classes of impairment due to mental and behavioral disorders" set forth in Table 14-1, relating to the impact of an impairment on the activities of daily living, social functioning, concentration, and adaptation. So it is suggested that pain be equated with a mental or behavioral disorder. We have not seen this tried yet but, again, it is probably coming.

It is noted that Chapter 14 is the only place in the AMA Guides which actually assesses workplace function. Especially in light of Guzman, we may be seeing more frequent attempts to utilize this chapter, not only in connection with the assessment of pain, but perhaps as an analogy to loss of function in connection with other injuries as well.

IV.

APPORTIONMENT

This topic was probably the issue getting the most attention at this convention. Applicant's attorneys still seem to be in a state of denial with respect to the new apportionment rules, suggesting that most apportionment determinations are speculative, unsupported by substantial evidence, or do not exist. One of the panelists, retired Judge Raymond Correio, asked a few questions of audience members with respect to their

understanding of apportionment, and, after considering the responses, pretty much bluntly told them that apportionment was now a fact of life, and they needed to deal with it. Apportionment is now mandated where, prior to Senate Bill 899, it would have been impossible to prove. Thus, apportionment may be based on non-industrial pathology, if it is established by substantial medical evidence that the non-industrial pathology caused permanent disability. Paredes v. WCAB, 72 C.C.C. 690 (2007) (writ denied). Paredes also stated that it was unnecessary to prove that the non-industrial pathology caused disability prior to the industrial injury, or that the pathology alone would have caused a particular amount of permanent disability absent the industrial injury. What is necessary, from the defense standpoint, is that the doctor show his work, i.e., explain his reasoning with respect to why he believes the non-industrial pathology plays a role in causing applicant's present disability. If he does not, there is no apportionment. Thus, in Fry's Electronics v. WCAB, 72 C.C.C. 131 (2007) (writ denied), applicant had a prior 1969 back injury with surgery, but testified he had completely rehabilitated himself. He supported this by evidence that he had worked without limitation for the past 20 years, and the QME apparently simply stated that 25% of applicant's overall disability was related to the prior back injury, without saying anything more about it. Since the doctor did not discuss the "how and why", the apportionment was disallowed.

On the other hand, in Jennings v. WCAB, 74 C.C.C. 543 (2009) (writ denied), applicant was determined to be 100% permanently totally disabled, although the Agreed Medical Examiner felt 40% of her overall disability was non-industrial related to prior back injuries and surgeries. He reviewed and discussed the medical records, diagnostic tests, and applicant's history of prior injury and surgeries, and discussed these factors in the context of his own medical expertise and the Board found that the apportionment determination was supported by substantial evidence. In Knoll v. WCAB, 74 C.C.C. 1379 (2009) (writ denied), an Agreed Medical Examiner found that applicant's disability to her wrist and

hands was 50% non-industrial based upon applicant's underlying rheumatoid arthritis. The Agreed Medical Examiner fully discussed the significance of applicant's arthritis, although the trial judge, despite an initial remand, insisted on two occasions in finding no apportionment. The Board found that the Agreed Medical Examiner had fully considered the significance of applicant's rheumatoid arthritis, and that the apportionment was warranted. Certainly, if the evaluating physician pays attention to the diagnostics and testing, and integrates a discussion of those results with his opinions on apportionment, the apportionment should be valid. See Clarkson v. Verizon, 72 C.C.C. ____ (2007). The same holds true in connection with findings during surgery, for example, Wallace v. WCAB, 72 C.C.C. 561 (2007) (writ denied), where the surgeon found extensive, pre-existing arthritis during the course of the surgery, and documented this, which proved to be a sufficient basis for upholding an apportionment.

The Applicant's Bar's traditional argument that apportionment calculations are "speculative" is generally based upon the proposition that the apportionment determinations are not "certain" or "exact". However, the standard is not certainty or exactitude, but reasonable medical probability. In Andersen v. WCAB, 149 Cal. App. 4th 1369 (2007) (citing Escobedo v. Marshalls, 70 C.C.C. 604 (2005)), the court cited that the fact that percentages are approximations which are not precise and which require some intuition and medical judgment does not mean that the conclusions are speculative. In fact, Labor Code §4663(c), specifically states that "a physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result" of industrial injury (emphasis added).

For a long time, it has been accepted that the Workers' Compensation Appeals Board was able to make a disability determination based upon a range of the evidence. See U.S. Auto Stores v. WCAB, 36 C.C.C. 173 (Sup. Ct., 1971). Fairly recently, The Board has determined that apportionment determinations based upon the range of the evidence were

appropriate as well. In Guild v. Kaiser Foundation Hospital, 2009 Cal. Wrk. Comp. P.D. Lexis 123 (2009), the Qualified Medical Examiner rendered an opinion that applicant had non-industrial apportionment in the range of 10% to 20% and the Workers' Compensation Appeals Board, noting that Labor Code §4663(c) spoke in terms of the "approximate" percentages of apportionment, found this was proper (the apportionment finding was based upon the bottom end of the range, or 10%). In O'Nesky v. WCAB, 72 C.C.C. 1555 (2007) (writ denied), the trial judge relied on applicant's QME to determine the overall level of permanent disability, but then used a range of the evidence standard to determine apportionment (explaining that applicant's credibility on the apportionment issue was somewhat suspect). This was found to be appropriate. In connection with testimony, it should be noted that a medical opinion on apportionment that is supported by substantial evidence, that opinion cannot be rebutted by an applicant's testimony alone. Sallay v. Macy's West, 72 C.C.C. ____ (2007). While there still may be some room for the application of Labor Code §3202 (liberal construction in favor of providing benefits), the Board has noted that this section never operates as a substitute for proof but finds its application in situations where a statute is truly ambiguous, or the evidence in a case is extremely close and subject to variable interpretations.

This discussion has primarily concerned itself with determinations under Labor Code §4663. Labor Code §4664 is another matter, and most of the decisions relating to this section have gone against the defendants. In retired Judge Correio's words, it is almost impossible for a defendant to establish true Labor Code §4664 apportionment. The root of this difficultly is Kopping v. WCAB, 142 Cal. App. 4th 1099, which held that defendant had the burden of proof on apportionment (nothing new here), including any issues relating to overlap (it is the word "overlap" which causes the problem).

The specific section in question is Labor Code §4664(b), relating to the conclusive presumption that prior permanent disability exists at the time of a subsequent industrial

injury, where applicant has received a prior Award of permanent disability. When this section was first enacted as a part of Senate Bill 899, the assumption in the workers' compensation defense community was that automatic apportionment was available simply upon submission of a copy of the prior Award. Especially as it related to disability ratings under the 2005 Permanent Disability Rating Schedule, however, applicant's attorneys early on began complaining that, since Awards under prior disability schedules were based upon different criteria than Awards under the 2005 Permanent Disability Rating Schedule, it was unfair to apply an automatic apportionment, and the courts have uniformly agreed with this, beginning with Kopping.

The basic idea is that rating methods under the two different Permanent Disability Rating Schedules are irreconcilable, so simply using the criteria used to rate the respective injuries is incapable of establishing overlap (since the criteria are completely different, i.e., inability to compete in the open labor market versus diminished future earning capacity). See Brault v. State of California, 2007 Cal. Wrk. Comp. P.D. Lexis 134 (2007). In Minvielle v. County Contra Costa, 36 C.W.C.R. 199 (2008), the Board noted that under Kopping, in order to obtain Labor Code §4664(b) apportionment, a defendant must prove both the existence of a prior Award and overlap of the permanent disability caused by the two injuries. However, when permanent disability is rated under different standards, overlap cannot be demonstrated or established under most circumstances.

Of course, nothing is impossible. Thus, in Martinez v. A.B.L. Trucking, 2008 Cal. Wrk. Comp. P.D. Lexis 248 (2008), applicant had an orthopedic injury in 2001, in connection with which he received a 37% Award, and a subsequent injury to the same body parts in 2006. The Agreed Medical Examiner found that applicant's current physical findings and subjective complaints were actually less severe than was recorded in connection with the 2001 injury, and the Board found that defendant established overlap pursuant to Labor Code §4664 (total overlap, actually, as applicant was awarded zero permanent disability in connection with the 2006 injury). Quite frankly, however, we are not sure whether this is really a Labor Code §4664 apportionment. Obviously, the Agreed Medical Examiner explained the "how and why" of his apportionment determination, but it certainly sounds to us that the same result here could have been reached under Labor Code §4663. The case does not really explain how overlap is established by the prior Award (indeed, the prior Award might not have even been necessary).

Because of the problems inherent in attempting to establish overlap in a Labor Code §4664(b) case, we have always felt that the real focus should be on establishing Labor Code §4663 apportionment, which can be approximated (as noted above). There is, of course, the problem associated with the fact that "rehabilitation" applies with respect to Labor Code §4663 apportionment (in Minvielle v. County of Contra Costa, applicant demonstrated to the Board's satisfaction that he had rehabilitated himself from the effects of his prior injury, so Labor Code §4663 apportionment was not available to the defendant).

Vigil v. San Diego Unified School District, 2009 Cal. Wrk Comp. P.D. Lexis 557 (2009) does suggest it may be possible to prove overlap based upon a prior Award if it can be shown what factors of disability under the new Permanent Disability Rating Schedule were present at the time of the prior injury (in other words, could applicant's prior disability be converted to an AMA Guides impairment), although the Board suggested that, in its view, it would be extremely difficult for a doctor to do this.

Where permanent disability Awards are calculated under the same permanent disability schedule, overlap is technically possible even if different body regions are involved. Thus, for example, in Oswalt v. WCAB, 71 C.C.C. 1243 (2006) (writ denied), applicant was awarded disability in connection with a 1997 right ankle injury, the disability factors of which completely overlapped a subsequent 2001 back injury, so Labor Code §4664(b) apportionment was found to be appropriate. The same was true in Rowe v. County of San Diego, 2009 Cal. Wrk. Comp. P.D. Lexis 470 (2009), where the defendant was able to establish Labor Code §4664(b) overlap with respect to a current hip and prior back injury.

The key, from the defense standpoint, relates to the burden of proof on apportionment. Apportionment is not automatic, and it is the defense's responsibility to establish it by substantial evidence. Failures of proof relate to apportionment as between inappropriate body regions (Lewis Tile v. WCAB, 74 C.C.C. 53 (2009) (writ denied) involved an unsuccessful attempt to apportion pre-existing psychiatric factors to the disability resulting from a brain injury) or simply a lack of diligence (San Mateo County Transit District v. WCAB, 73 C.C.C. 438 (2008), applicant's background was not investigated prior to the close of discovery, so his three prior industrial injuries were not considered in connection with the issue of apportionment).

Perhaps the most interesting observation, however, relates to applicant's physician (either a free-choice treater or a QME), in relation to their compliance with the requirements of Labor Code §4663. Obviously, if a defendant expects apportionment, the defendant must present substantial medical evidence on that issue. On the other hand, while applicant's doctor is certainly required to discuss the issue under Labor Code §4663, we somewhat cynically note the Board's observation that it does not matter whether an applicant's medical report is conclusory on the issue of apportionment, thus not constituting substantial medical evidence on the issue, since it is the defendant's burden of proof. Grossmont Hospital v. WCAB, 71 C.C.C. 85 (2007) (writ denied).

With respect to pre-existing conditions (or so called "risk factors"), arthritis is certainly no surprise (Wallace v. WCAB, 72 C.C.C. 561 (2007) (writ denied); significant pre-existing arthritis discovered by the surgeon during the course of a knee surgery), as well as obesity (Andrews v. Freezer Queen Foods, 73 C.C.C. _____ (2008), applicant's obesity was a factor in causing her knee condition and resulting disability); and see also Republic Indemnity Company of American v. WCAB, 72 C.C.C. 1175 (2007) (writ denied).

The controversial risk factors relate to age and gender (primarily in connection with the development of degenerative disc disease). There are several cases in which this issue was argued: Kos v. Kimes-Morris Construction, 72 C.C.C. ____ (2007) (degenerative disc disease, most of which was apportioned to non-industrial factors, and in connection with which applicant argued this was invalid, since this was an age-related disease); Seabright Insurance Company v. WCAB, 36 C.W.C.R. 32 (2008) (unpublished decision) (in which applicant argued that, since osteopenia is an age and gender-related condition, apportionment to it should be invalid); Vaira v. WCAB, 72 C.C.C. 1586 (2007) (unpublished decision) (apportionment to an age-related degenerative condition was unconstitutional). All of these challenges were rejected, and with good reason. None of the apportionment urged in these cases had anything to do with age. All of the apportionments were directed to physical conditions/disabilities which contributed to applicant's overall permanent disability (even though such non-industrial disability might well have some relationship to a person's age or gender). The fact of the matter is that the apportionment was to an objective medical condition which might have been incidentally related to age (Vaira specifically pointed out this distinction).

Where the attempt at apportionment is, in reality, to a factor such as age, without anything else, that will be invalidated. Thus, we have Gibson v. Mendocino Solid Waste Management Authority, 72 C.C.C. _____ (2007), where the QME apportioned 25% of applicant's disability to "degenerative aging". That, of course, was inappropriate (the judge

stated that, in his opinion, no experienced workers' compensation professional would conclude this apportionment determination to be valid), and it was disallowed.

In addition to this, some of the more controversial issues of apportionment are as follows:

1. Joint Replacement Cases. The trouble here started with City of Concord v. WCAB (Steinkamp), 71 C.C.C. 1203 (2006) (writ denied) and Kien v. Episcopal Homes Foundation, 34 C.W.C.R. 228 (2006) which formulated the so called "Steinkamp theory" due to the fact that a joint replacement surgery removes the pre-existing degenerative condition, so that there is no basis for a Labor Code §4663 apportionment (Steinkamp suggested that the defendant was attempting to apportion medical treatment).

These cases have been pretty much uniformly rejected by the cases following them. In Stocks v. Urban Group, 2007 Cal. Wrk. Comp. P.D. Lexis 233 (2007), the Board stated that, while applicant's degenerative joint disease was no longer present after the joint replacement surgery, the pre-existing joint disease certainly contributed to applicant's need for the joint replacement, which itself caused applicant pain and limitation. The Board noted that the current approach to apportionment is to look at the current disability, and parcel out its causative sources, and thus found that apportionment was proper.

Although it is an unpublished decision (what would cause the court not to publish an opinion on such an important issue is a mystery), Williams v. WCAB, 74 C.C.C. 88 (2009) states in no uncertain terms that when medical evidence establishes that a combination of factors results in the need for surgery and consequent permanent disability, causation of the permanent disability lies with all of those factors, even the pathology removed by the surgery.

By no means, however, does this mean that the apportionment issue is now a "slam dunk" for the defendant. So, where the defendant fails to establish that the need for the knee

replacement surgery was caused by the underlying degenerative condition, there likely will be no apportionment. Young v. Inns of the Monterey Peninsula, 2009 Cal. Wrk. Comp. P.D. Lexis 183 (2009). See Alvizo v. State of California, 2009 Cal. Wrk. Comp. P.D. Lexis 152 (2009), where the Agreed Medical Examiner indicated that applicant's permanent disability was due to the poor results of her knee replacement surgery, and that the underlying pathology did not contribute to those poor results. One of the keys here may actually relate to the severity of the injury itself. If the industrial injury is truly a significant one, resulting in a lot of damage, apportionment to a pre-existing condition (especially if there is not much by way of pre-existing symptomology) is likely to be minimized.

2. Psychiatric Injuries. Labor Code §3208.3, requiring that, in order to establish a compensable injury, an applicant is required to show that "actual events of employment were predominant as to all causes combined to the psychiatric injury" has always been the subject of some conflict. In TruGreen LandCare v. WCAB, 75 C.C.C. 385 (2010) (writ denied), applicant sustained a specific psychiatric injury as the result of his witnessing the death of a co-worker. Subsequently, he sustained an industrial back injury, in connection with which there was a compensable psychiatric component. Overall, applicant's psychiatric disability was apportioned 40% to the specific psychiatric injury, 40% to the compensable consequence of the back injury, and 20% non-industrial. Defendant argued that the applicant had no compensable psychiatric disability, since no one injury was the predominant cause of applicant's psychiatric disability. The judge, and the Board, disagreed finding that the predominant cause of applicant's psychiatric disability was the combined results of the two industrial injuries. Defendants claim that there was an improper "merger" of both dates of injury, was rejected, then the Board determined that defendant was improperly attempting to use Labor Code §4663 apportionment to determine causation of injury.

It was noteworthy that Labor Code §3208.3 only mentions "actual events of employment" in a general sense, and does not seem to restrict those events to any particular injury. Although the TruGreen case involves separate injuries with the same employer, there seems to be no reason why this same rationale could not be used where separate injuries occur with different employers.

A different twist on the predominant cause argument appeared in San Francisco Unified School District v. WCAB, 75 C.C.C. 76 (2010) where a school teacher claimed a cumulative trauma psychiatric injury. She claimed her problems arose out of stress in the classroom, while the District claimed her psychiatric symptoms were the result of an adverse reaction to a good faith personnel action. An Independent Medical Evaluator apportioned 15% to non-industrial factors, and 85% to industrial factors, dividing the remaining 85% between classroom stress (60%) and the personnel actions (40%) (the personnel actions were apparently found to be in good faith). The defendant argued that since 40% of the industrial component was due to a good faith personnel action, Labor Code §3208.3(h) applied (non-compensable if the injury is substantially caused by the good faith personnel action, with substantial cause being defined as 35% to 40%). The Board disagreed, determining that apportionment had to be considered in connection with applicant's overall psychiatric disability. When done in this manner, the personnel action was not a substantial cause of applicant's psychiatric disability under the statute (it amounts to only 31%), and applicant's claim was compensable because the classroom stress accounted for 51% of her overall disability.

3. Petitions to Reopen. The leading case is Vargas v. Atascadero State Hospital, 71 C.C.C. 500 (2006, en banc), holding that the apportionment provisions of SB899 apply to any petition to reopen that was pending and not final at the time SB899 was enacted on April 19, 2004, but that the new apportionment statutes cannot be used to revisit the level of permanent disability (or the presence or absence of apportionment), determined under a

final Award issued before April 19, 2004. In other words, apportionment can apply to the increased disability above and beyond the original Award, as long as the apportionment determination is supported by substantial evidence. See Johnson v. City of Los Angeles, 74 C.C.C. 1 (2009) (unpublished).

4. Benson Issues. Lest we forget, Benson v. WCAB, 170 Cal. App. 4th 1535 (2009) found that the adoption of SB899 abrogated the Wilkinson doctrine, which essentially permitted the merger of permanent disabilities. Benson requires that separate injuries must be separately rated. The Benson rule only does not apply in that "exceptional case" when the reporting doctor is unable to separate the permanent disability resulting from each injury. Stepp v. County of Contra Costa, 2010 Cal. Wrk. Comp. P.D. Lexis 155 (2010). In Roberts v. State of California, 2009 Cal. Wrk. Comp. P.D. Lexis 320 (2009), the workers' compensation judge indicated applicant was entitled to a combined Award, because it was "impossible" to separate out the disabilities caused by two injuries. The Agreed Medical Examiner had been able to identify the subjective and objective factors of disability with respect to each body part, and the WCAB found that this was enough to support separate Awards, remanding the matter back to the judge.

A somewhat strange case is Lockheed Martin Aircraft Services v. WCAB, 74 C.C.C. 1385 (2009). Applicant sustained two specific right shoulder injuries in 1995 and 1998, with compensable consequence psychiatric and complexing regional pain syndrome injuries. Applicant was deemed permanent and stationary in 2007, and was found totally disabled as a result of the combination of both injuries. Applicant's QME indicated that apportionment to the residual permanent disability could not be made with reasonable medical probability, although the defense QME indicated there was a 50/50 apportionment.

The determination that applicant was entitled to the combined injury was apparently based upon the fact the most significant of the injuries occurred in 1995, and the medical evidence was to the effect that the 1998 injury might almost be considered an exacerbation

(this was the opinion of applicant's QME). If that was the case, there really was no separate injury, and the Board felt that applicant's QME had defended his opinion that it would be speculative to apportion between the two injuries based upon his specific discussion as to why he felt that to be the case.

In CIGA v. WCAB, 74 C.C.C. 1469 (2009), there was an attempt to establish two separate cumulative trauma injuries following a specific injury occurring in 1997. The medical evidence was to the effect that the cumulative trauma injuries were not really separate injuries at all, but rather were compensable consequences of the 1997 injury. Thus, there was no basis for Benson apportionment.

5. LeBoeuf Cases. LeBoeuf v. WCAB, 48 C.C.C. 587 (1983) essentially allowed a rebuttal of a partial permanent disability rating derived from the then existing Permanent Disability Rating Schedule based upon medical evidence that an applicant was unable to compete in the open labor market, and thus 100% totally disabled. In Nooner v. City of San Diego, 74 C.C.C. 300 (2009) (writ denied), a 1997 Permanent Disability Rating Schedule case, the judge found applicant totally disabled based upon applicant's inability to compete in the open labor market, and stated his opinion that no apportionment was available where such a finding was made. Defendant's petition for reconsideration was granted, with the Board stating that LeBoeuf is a factor to be considered in determining applicant's overall disability before apportionment, but that it does not preclude apportionment. To a certain extent, when dealing with a LeBoeuf finding, this apportionment can actually extend to so called cultural factors. Thus, in Sherron v. American Casualty Company, 36 C.W.C.R. 201 (2008), applicant was found to be totally disabled, but 26% of this disability was found to be the result of a pre-existing learning disability, and was found to be the proper basis for apportionment.

It is possible that non-industrial apportionment with respect to one aspect of industrial injury may not matter at all, if there are multiple causes of disability. Thus, for example,

Guild v. Kaiser Foundation Hospital, 2009 Cal. Wrk. Comp. P.D. Lexis 123 (2009) involved a case where applicant had orthopedic and psychiatric disabilities, and, although there was apportionment with respect to the psychiatric disability, the back injury itself (in connection with which there was no apportionment) was substantial enough to cause 100% disability without the psychiatric injury.

Kaiser Foundation Hospital v. WCAB, 71 C.C.C. 538 actually involved two apportionment issues, one relating to the availability of apportionment in connection with the presumptive total disability established by Labor Code §4662(d) (loss of use of both hands), as well as the prohibition in Labor Code §4664(c), precluding the accumulation of permanent disability Awards exceeding 100% with respect to any one region of the body. Defendant noted applicant had a prior 18¾% permanent disability Award with respect to her wrist, also suggesting it was entitled to a subtraction of this Award pursuant to Labor Code §4664(b). Defendant lost on all counts. The Board found that the conclusive presumption in Labor Code §4662(d) trumps Labor Code §4664, specifically noting that Section 4664(c) does not apply to conclusively presumed total disabilities under Labor Code §4662.

In passing, one of the panelists, Arthur Lipper, M.D., observed that very few evaluating physicians are paying much attention to the use of certain substances (as opposed to outright substance abuse) in connection with sleep, heart, or hypertension claims. The usual suspects in connection with these claims (recreational drugs, alcohol, tobacco) generally receive some consideration, but he states he almost never sees physicians investigating whether patients are using energy drinks, herbal medications, or vitamin enhancers. He feels these substances can have a dramatic impact with respect to the ability to sleep, as well as internal medicine factors. This may be further fodder for discovery.

V.

MSAs AND STRUCTURES

In connection with Social Security Disability (and Medi-Care), applicant's attorneys need to be concerned with two things: Potential setoffs resulting from a workers' compensation settlement (use of the so called Hartmann formula; defendants generally do not concern themselves with this) and the Medi-Care secondary payment rules (with which defendants do concern themselves).

Even in connection with secondary payments, at least in connection with post-settlement payments, the burden has always been on the worker. The only clear obligation owed by a defendant in connection with Medi-Care payments relates to secondary payments in connection with treatment of an industrial injury made prior to a Compromise and Release settlement. 42 U.S.C. §1395y(b)(2)(B)(iii) (potential damages if Medi-Care program interests are ignored with respect to prior medical payments.

Regarding future payments, 42 C.F.R. §411.46(b)(2) bars efforts to improperly characterize workers' compensation settlements so as to shift to Medi-Care responsibility of payment for treatment of work-related conditions. Subsection (d) provides that if a lump sum compromise settlement forecloses the possibility of future payment of workers'

compensation benefits, medical expenses incurred after the date of the settlement are payable under Medi-Care, unless the settlement agreement allocates certain amounts for future medical services. If that occurs, Medi-Care does not pay for those services until the medical expenses relating to the injury equal the amount of the lump sum settlement allocated to future medical expenses.

This is the basic regulation. It is clear that the so called "lump sum compromise settlement" referenced in subdivision (d) is not the same as the normal Compromise and Release; what is contemplated is a small settlement of a completely disputed claim, essentially the type of settlement which would include the equivalent of a "Thomas waiver" (and even Thomas waiver settlements would probably not fall under this exception if they involved exceptional amounts of money).

The point, however, is that this particular regulation basically defines the obligations of the parties, and the remedies of Medi-Care, in the most general terms, as they relate to workers' compensation settlements. The key remedy for Medi-Care (by and through its servicing agent, CMS) is that Medi-Care will not pay for an applicant's medical treatment services until the medical expenses related to the injury equal the amount of the lump sum settlement allocated to future medical expenses. There is absolutely nothing in the regulations suggesting that CMS/Medi-Care has any right of action against the defendant for reimbursement of post-settlement medical care, although CMS has buffaloed a lot of people into believing that they do.

Most of the bluster arises out of a series of informational memorandums issued by CMS (and for the most part entitled "Frequently Asked Questions"). These memorandums do not really have the force of law, but CMS governs itself as if they do. There is no statute or regulation which establishes the requirement of preparing a Medi-Care Set-Aside allocation (MSA) in connection with a Compromise and Release settlement. This device has its genesis in a July 23, 2001 document entitled the "Patel Memorandum", authored by CMS

Deputy Director Parashar Patel. The memorandum initially makes the erroneous assumption that liability is disputed in most workers' compensation cases, and that it is very common that Medi-Care finds that it has made secondary payments (untrue on both counts). It distinguishes between "commutation cases" and "compromise cases" (for our purposes, the commutation cases are essentially the normal Compromise and Release on an admitted industrial injury claim, while the compromise cases would be those which would normally be subject to a Thomas waiver). It is assumed that the settlements in these latter cases are relatively low, and there is no requirement that Medi-Care's interests be taken into consideration.

In connection with the commutations (or large compromise cases), there are minimum review thresholds. If an applicant is already entitled to Medi-Care coverage, the CMS review threshold is $25,000.00 (CMS will not review a Medi-Care allocation in a settlement less than this). Where there is no reasonable expectation of Medi-Care enrollment within 30 months of the settlement date, the review threshold is $250,000.00. CMS does not consider these to be safe harbors; the memorandum requires that Medi-Care's interests be taken into consideration, and simply advises that Medi-Care will not review the allocations.

This memorandum sets forth the basic criteria by which MSAs are evaluated, with one of the criteria being the medical expenses paid by the workers' compensation carrier in the several year period prior to settlement, and after the medical condition is stabilized. MSAs are not reduced to present day value, and medical charges can be based upon workers' compensation Fee Schedule rates only if the workers' compensation carrier retains the ability to enforce the Fee Schedule (at least in connection with a self-administrated MSA, this is never).

Medi-Care advises in a subsequent memo that, if CMS agrees to a Medi-Care Set-Aside, applicant can be certain that Medi-Care's interests have been appropriately considered. There is no appeal from a MSA determination by CMS, and Medi-Care will not

recognize a settlement in which the MSA has not been approved. It will generally honor judicial decisions after a hearing (not judicial decisions approving settlement), and attorneys' fees must be derived from a source other than the MSA.

Here is the hammer: The Frequently Asked Questions memorandum dated April 22, 2003 states that Medi-Care does not pay for an individual's workers' compensation related medical services when that individual received a workers' compensation settlement, judgment, or Award that includes funds for future medical expenses, until such funds are properly expended. If CMS determines that Medi-Care's interests were not properly considered in a settlement (either by an MSA or otherwise), then Medi-Care will not make payments related to the subject injury or illness until such time as sums expended for services otherwise reimbursable by Medi-Care exhaust the entire settlement (in other words, Medi-Care will assert a credit in the amount of the entire settlement against its liability for future medical care payments).

There is no statute, regulation, or other legally binding requirement that an MSA be prepared, and submitted to CMS for approval. But CMS is treating its memorandums as legally binding authority. That is bad for the applicant, if CMS ever decides to audit the thousands of settlements which are submitted to it (to date, there does not seem to be much evidence of this).

As a practical matter, however, from a defendant's standpoint, unless there is an intent to actually participate in a conspiracy to defraud Medi-Care, once a defendant has entered into a Compromise and Release Agreement, we do not believe that Medi-Care has any further right of action against the defendant.

Here is something interesting for applicants to consider, however. In connection with certain "means-tested programs", such as "Medi-Cal", qualification for such programs depends upon the availability of resources, and a self-administered MSA is not necessarily exempt from consideration as a "resource". Thus, the existence of a self-administered MSA

as a part of a workers' compensation settlement may preclude an applicant from qualifying for a means-tested program, such as Medi-Cal.

Note that the following types of services would be considered non-Medi-Care future medical expenses: Attendant care; home healthcare; holistic modalities (more than likely, you will not see much of this once an applicant is outside of the workers' compensation system); gym membership; weight loss; massage therapy; chiropractic care; home modifications; adaptive equipment; transportation; detoxification and drug rehabilitation programs. We see some Medi-Care vendors actually including the cost of these services in their overall MSA proposals, which gives these proposals the character of a life care plan. Unfortunately, we think they also tend to give applicants unreasonable expectations with respect to the value of their cases, and those tend to make settlements more difficult.

On the issue of structured settlements, we know many of our clients would prefer to settle cases in this manner. The mechanics are not terribly difficult, with the primary initial disputes relating to which structured settlement broker will be used (defendant's broker, who will try to steer the business to a company associated with the defendant, or an applicant's broker, who will shop the entire market for the purpose of browbeating the defendant's company into providing the most advantageous plan; the usual result is that the two brokers end up splitting the commission).

There is a slight issue, however, which merits some attention, and that relates to the guarantee of payments with respect to the annuity which funds the structured settlement. With some of the larger carriers which utilize affiliates to issue the annuities (Liberty Mutual is mentioned as one), the parent company provides the guarantee in the event the annuity issuer becomes insolvent. What happens, however, if the applicant's structured settlement specialist obtains a deal from an outside carrier that the defendant's affiliate cannot match, with the result being that the outside carrier is the one which issues the annuity?

Applicant's attorneys may be recognizing this problem, and convention attendees were being advised to obtain a guarantee from the employer/insurer that the employer/insurer would become responsible for the remaining annuity payments if the annuity issuer becomes insolvent. Some opinion was expressed that, in the case of a structured settlement, the employer/insurer remains liable for these payments, but we doubt it. The Compromise and Release cuts off the employer/insurer's liability. The consideration is the payment to be under the Compromise and Release, whether that is in a lump sum, or by way of a structure from a separately purchased annuity. So, in the absence of a guarantee by the employer/insurer, we seriously doubt that there would be any remaining liability in the event of an insolvency by the annuity issuer.

We would be hesitant to recommend such a guarantee. We could understand it if a defendant were using its own affiliate to issue the annuity, but could see no basis for recommending the guarantee at all if an applicant insists upon using an outside company.

VI.

PROCEDURAL ISSUES AND APPEALS

This section relates to those situations where we have been unable to settle the case, and a trial becomes necessary. After all the testimony is in, the prelude to the compensable Findings and Award will be the trial judge's rating instructions, and the Disability Evaluation Unit's recommended rating. Although not necessarily a requirement, if there is dissatisfaction with either the rating or the instructions, there are several post-trial motions available: The most simple is the request to cross-examine the rater, although the motions for this procedure have become increasingly complexing, to include not only the motion to cross-examine the rater, but also a motion to strike the rating (basically, a challenge to the judge's rating instructions), and a motion to submit rebuttal evidence (dragging your private rater to the Board for the purpose of submitting his opinion with respect to how the case should be rated).

The first appellate level is reconsideration, the petition for which must be filed within 20 days of the issuance of the decision (with a five day extension for service by mail) (Labor Code §5903; Code of Civil Procedure §1013; Regulation 10507). If the petition is not filed timely, there is no jurisdiction, although there are some limited exceptions in the event there is defective service of the trial judge's decision.

The rarified air begins at the review levels beyond reconsideration. The next step is the petition for writ of review with the appropriate District Court of Appeal. This petition must be filed within 45 days of the filing of the WCAB order, decision, or Award (with no five day extension) (Labor Code §5950). There is a time extension if the final day falls on a Saturday, Sunday, or holiday (Labor Code §5954; Code of Civil Procedure §12), and, again, there is no jurisdiction if the petition is untimely. There are, again, due process exceptions if there was defective service of the WCAB order.

The most important thing to remember is that these writs are discretionary. Statistically, 80% to 90% of these review petitions are denied, most of them summarily without hearing.

With respect to evidentiary issues, the standard of review is "substantial evidence". This means that, no matter how unjustified a party might feel the decision was, if there is substantial evidence supporting it, too bad. The only "de novo" issues the court will consider are those primarily relating to the interpretation of statutes.

Assuming one is not happy with the decision of the Court of Appeal, the next (and in almost all cases, final) step is a petition for review to the Supreme Court, which is ten days after the Court of Appeal decision becomes final (one of the little postcards with "writ denied" on it is final when it is mailed, so the ten days begin running then). The chances for success here are even less than in the Court of Appeal, so unless one has a truly unique or interesting issue, the chances of a Supreme Court review are probably not too good.

From a defense standpoint, these judicial steps need to be carefully considered. First, the filing of a petition for writ of review does not automatically stay the decision in question. Failure to pay an outstanding Award when filing of a petition for review could be considered an unreasonable delay, if the defendant has not obtained a stay from the reviewing court (and this may require the payment of an undertaking).

Secondly, if the appellate court feels that the review petition was without substantial merit (no reasonable basis), it may order an Award of supplemental attorneys' fees against the carrier (Labor Code §5801). The danger here is that if the court finds there is no reasonable basis for the petition, a trial court may find there was no reasonable basis to delay paying the Award, and the defendant will find itself faced with a penalty situation, as well.

VII.

OTHER ISSUES

This is probably more pertinent to employers than carriers (other than the responsibility for the 15% enhancement on permanent disability benefits and the supplemental job displacement voucher), but one of the panels was taking a long look at an employer's failure to return an applicant to work following an absence for industrial injury. The most common scenario relates to an employer terminating employment on the basis that medical work restrictions and activity restrictions conflict with the requirements of the job. The panelists reference California's Fair Employment and Housing Act (FEHA), which actually has broader protections than the federal Americans With Disabilities Act (ADA). FEHA defines employees covered by its disability discrimination protection so broadly that it probably includes any industrially injured worker, and there are cases which are read for the proposition that if an employer terminates an employee because it believes the employee's medical restrictions preclude him from doing the job, this fact alone should establish that the employer perceives or regards the employee as having a disability. See Gelfo v. Lockheed Martin Corporation, 140 Cal. App. 4th 34 (2006).

The panelists argue that it is an employer's misconception that compliance with workers' compensation obligations obviates compliance with the duties imposed by FEHA which is often the essence of an accommodation claim relating to an industrially injured worker. Under the FEHA, it is an actionable unlawful employment practice for an employer to fail to engage in a timely, good faith, interactive process with the employee to determine effective reasonable accommodations. Government Code §12940(n). This process involves an exchange between the employer and employee involving the sharing of information (Prilliman v. United Airlines, 53 Cal. App. 4th 935 (1997); and should identify the precise limitations resulting from the disability and potential reasonable accommodations that could overcome those limitations. 29 C.F.R. §1630.2(o)(3). EEOC enforcement guide (EEOC

Notice No. 915.002, September, 1996), states that an employer cannot substitute vocational rehabilitation services in place of a reasonable accommodation for an employee with a disability-related occupational injury, and the Gelfo case stated that a policy requiring that an employee be 100% healed before returning to work is a per se violation of the Act. Jensen v. Wells Fargo Bank, 85 Cal. App. 4th 245 (2000) states that an employer has a duty to reassign a disabled employee if an already funded, vacant position at the same level exists.

The situation most of us see is one where the employee simply displays no interest in returning to work, but from time to time, we are all faced with the exception. Most of the time, a termination under these circumstances will result in the filing of a Labor Code §132a petition, but we do not really see much beyond that. However, the employer is certainly at risk if it does not keep these statutes in mind.

There are, of course, defenses. We are familiar with the case where an applicant, as a practical matter, has no intention of returning to the job, but uses the fortuitous circumstance of a termination to file a discrimination claim for the purpose of boosting the value of his case. The medical evidence can provide defenses to these types of claims, primarily in the form of judicial estoppel, that is, the employee's position in the workers' compensation matter (so disabled that he will never be able to work again) is inconsistent with the position taken in the discrimination case (I was fired and want my job back). On the other hand, attorneys representing workers in these cases assert that even a finding of permanent total disability would not judicially estop a worker from pursuing an FEHA claim based on a failure of the employer to consider a reasonable accommodation (the test being whether the employee is capable of performing "essential functions").

On the subject of employers, two cases involving serious and willful misconduct, Bigg Crane and Rigging Company v. WCAB, 75 C.C.C. 1089 (2010) and Ford Construction Company v. WCAB, 75 C.C.C. 953 (2010) have reiterated some general rules relating to a successful serious and willful misconduct claim: Applicant is required to prove that an executive or managing officer had discretionary power to direct at least an integrated department (so this does not include the supervisor who is not considered a manager); the mere violation of a safety order, alone, is not sufficient to prove serious and willful misconduct, which requires that an executive or managing officer, basically, recklessly disregard an obvious danger, and that the mere proof of negligence is insufficient to prove serious and willful misconduct.

Applicant's attorneys are unhappy. They suggest legislative changes are in order to make it easier to win these cases, and that an automatic benefit enhancement should be mandated for the violation of a safety order, without having to prove a serious and willful misconduct claim. All of this ignores, of course, the benefit tradeoff whereby an employee is guaranteed benefits for an industrial injury, and the employer is insulated from a negligence action. Serious and willful misconduct is essentially an exception to this benefit bargain, and requires misconduct which borders upon intentional harm. It is an uninsurable claim, which means that many small companies could be financially ruined by such an Award. We find it somewhat odd that applicant's attorneys' enthusiasm for this type of claim is not tempered by this realization.

The uncertainty created by the depublication of the Miceli case regarding the availability of other insurance as between the general and special employer appears now to have been resolved in the case of Fireman's Fund v. WCAB, 75 C.C.C. 1123 (2010), which essentially provides that Labor Code §3602(d), which allows a general and special employer to designate one party as the provider of workers' compensation coverage, does not extinguish the joint and several liability of each employer for those benefits. As a result, the

special employer's coverage constitutes other insurance when the carrier for the general employer becomes insolvent.

The result might have been different had the Fireman's Fund policy contained an exclusion for employees who were contractually under the workers' compensation coverage of the general employer, but the Fireman's Fund policy provided unlimited coverage for all employees of the special employer.

The flipside of an issue which developed several years ago (defendants in civil cases attempting to use workers' compensation Compromise and Release Agreements to escape civil liability) has appeared in the case of Steller v. Sears, Roebuck and Company, 75 C.C.C. 1146 (2010). In this case, applicant settled a FEHA case by accepting a Code of Civil Procedure §998 offer for judgment which provided that acceptance resolved and released the defendant from all demands, actions, liabilities, obligations, damages and/or causes of action arising from this lawsuit or relating to applicant's employment with the employer. Applicant accepted, and then the litigation commenced over the interpretation of the judgement, i.e., whether it constituted a resolution of applicant's pending workers' compensation claim. The Court of Appeal ruled that it did, although it also ruled that Labor Code §5001 and §5002 required that the WCAB must also approve the settlement.

Applicant attorneys claim that this ruling conflicts with the Supreme Court's decision in Claxton v. Waters, 34 Cal. 4th 367 (2004), but it clearly does not. Claxton involved the interpretation of a Compromise and Release, and the rules relating to Compromises and Releases are quite a bit more stringent than those related to the settlement of civil actions in the superior court.

A couple of matters of interest relate to the class action for attorneys' fees which the plaintiffs attempted to pursue in Koszdin v. SCIF, 75 C.C.C. 711 (2010), where it was claimed that defendants were welching on post-Award interest accruing on attorneys' fees. The court confronted two issues, whether the plaintiffs had standing to bring the complaint, and secondly whether the court had jurisdiction to consider it. The court determined that interest on post-Award attorneys' fees was payable directly to the attorneys, so the attorney plaintiffs did have standing to pursue the case. However, the remedy was within the exclusive jurisdiction of the WCAB, so the court lacked jurisdiction, and the plaintiffs were out of luck.

In Alvarez v. WCAB, 75 C.C.C. 817 (2010), involving the ex parte contact between a Qualified Medical Examiner and a defense attorney, the Court of Appeal reissued its original decision, essentially affirming its prior holding, that pretty much any type of ex parte contact was prohibited, and constituted grounds for assignment of a new QME. The only exception was "incidental communication" between a party and the QME/AME, which was unrelated to the case or evaluation (we assume, social communication).

This is a trap. We do suggest that the prohibited communications include both administrative or substantive communications (in this case, the QME contacted the defense attorney to advise her that he was missing some records which he had agreed to review, and requested that they be resent). Our advice: Avoid the phone calls, except when absolutely necessary to set appointments, and make sure that documents transmitted to the QME are appropriately served as required by the regulations.

VIII.

CONCLUSION

We may be wrong, but we really do not think that much on the legislation front (major legislation anyway) is going to be happening in the near future. We may have a better idea of what is planned (or hoped) at the time of the next convention. It appears that the governor and the legislature are presently primarily focused on the economy and that is likely to command their attention for the foreseeable future.

From what we heard, the initial legislative focus is going to be with respect to apportionment, (and perhaps a revamp of the permanent disability schedule), and an attempt to limit the types of apportionment available in connection with degenerative type change (on the basis that it is de facto age or gender discrimination). CAAA may actually have the votes in the legislature to do this. It was not really considered a threat when it was proposed about a year ago, since then Governor Schwarzenegger was not about to sign it, but current Governor Brown might. If anything happens by the time of the next convention, this might be it.

Although Guzman is final, there are other schedule rebuttal cases with petitions still pending, and we do note the Supreme Court has yet to decide the Duncan case with respect to the appropriate commencement date for COLA increases. On top of all this is talk that a new Permanent Disability Rating Schedule is in the works (and some incidental conversation that it might actually be statutory, since there is rumor that horse trading on the schedule may result in a mooting of the Ogilvie problem.).

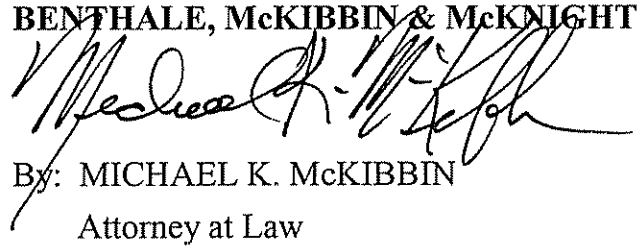
So far, however, everything is vague, but it is clear people are probably talking behind the scenes. Clearly, however, with the present administration, we do not expect to see the system become any more restrictive. We do understand some carriers are suggesting that their claim costs have significantly risen (interestingly, primarily related to medical

expense), and that their profit margins are disappearing. That, unfortunately, does not bode well for the system.

Until the next convention, we remain,

Very truly yours,

BENTHALE, McKIBBIN & McKNIGHT



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