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THE DEFENSE PERSPECTIVE AND OBSERVATIONS OF THE CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION 2016 SUMMER CONVENTION

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2016 SUMMER CONVENTION OF THE

CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION

JUNE 30 - JULY 3, 2016

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I.

INTRODUCTION

TO OUR CLIENTS:

We are pleased to report with respect to the events and ideas presented in connection with the 2016 Summer Convention of the California Applicants' Attorneys Association held June 30, 2016 through July 3, 2016 in San Francisco. Somewhat surprisingly, given the group's orientation, there was little vitriol or gnashing of teeth with respect to the present state of workers' compensation, especially as it related to the changes which were created by the major reforms represented by the Senate Bills 899 and 863. There were the usual claims that the system is unfair to workers, especially in connection with utilization review of medical treatment, but it does appear that applicant's attorneys have settled in and, if not wholeheartedly embracing the Senate Bill 899 and 863 changes, there appears to be at least resigned acceptance and acknowledgment of the ability to work with the law that exists.

Legislatively, there does not appear to be anything terribly significant on the horizon at this point. The Workers' Compensation Appeals Board is still short a couple of commissioners, and it is unclear that Governor Brown is in any hurry to fill the vacancies. There seems to be a consensus among the applicants crowd that Governor Brown is more unfriendly to applicants' workers' compensation than Arnold Schwarzenegger ever was, partly because SB 863 was enacted under Brown's watch. With that in mind, we will take a look at some of the plans, proposals and ideas suggested by the workers advocates tempered, of course, by our own comments and ideas.

II.

MED-LEGAL TREATMENT AS TEMPERED BY UTILIZATION REVIEW

Applicant's attorneys, as a group, continue to hate Utilization Review, complaining that it is biased against providing medical treatment to the detriment of their clients. The most common type of Utilization Review is prospective, which most of us contemplate is to be accomplished within five working days of the submission of a Request for Authorization. Applicant's attorneys complain that Utilization Reviews always takes five days, which, they feel, actually contravenes the statute [Labor Code §4610(g)], which provides that Utilization Reviews are to be completed in a timely fashion that is appropriate for the employee's medical condition not to exceed five business days. The panel urges the members to challenge timeliness even if the review is completed within five business days, assuming it could be argued that even five business days was not timely given the employee's medical condition (however, if the medical condition so warranted less time, one has to wonder why the physician did not ask for an expedited review).

One issue of timeliness relates to the communication of the Utilization Review decision to the treating physician. However, applicant attorneys suggest that communication of the final decision is not the only facet of communication, but that the so-called "peer review", or telephonic contact, attempted with the treating physician prior to the issuance of the Utilization Review decision is also part of the communication. The defense faults applicant's treating physicians for ignoring the Utilization Reviewer's attempts to telephonically discuss applicant's case prior to making a Utilization Review decision (with very few exceptions, the Utilization Review Report notes that Utilization Reviewer attempted

calls to the treating physician, left messages, but with no return calls; several years back there was actually a chiropractor who told the group it was his practice not to discuss matters with Utilization Reviewers). Applicant's attorneys insist that an implied requirement of this telephone message, however, is that the Utilization Reviewer must advise that it is his intention to decertify the medical care, a part of the message which very infrequently appears in the Peer Review Report. The better practice would probably be to make this a part of the message, and to include it in the report, although we are certain that most primary treating physicians, when they receive a message that Utilization Reviewer has called to talk with them about the patient, probably know it is not to chat.

Another common complaint from the applicant's bar is that the Utilization Reviewer is given little by way of information in connection with the treatment decisions Utilization Review is called upon to make. Whether it is because limited documentation is being submitted with a treatment request, or the Utilization Reviewer is simply is not reviewing everything which is available to him, in many cases it does appear true that little by way of medical information is cited by the Utilization Reviewer in the decertification decision. As a practical matter, we think the Utilization Reviewer, at a minimum, should have all medical-legal reports, and some sort of a record with respect to applicant's treatment history.

There are several applicant's attorneys who are taking the position that, rather than pursuing IMR, they are seriously considering filing penalty and/or sanction petitions based upon the claim that the Defendant has not reasonably investigated the medical treatment request (citing Rule 10109, see infra) and on the further ground that appropriate service of medicals have not been made. How such a claim will fare is unclear, although at least one of these cases is presently pending at the San Jose Workers' Compensation Appeals Board (Case No. ADJ 10124565).

We assume that the failure to serve medical reports argument probably has more relevance with respect to IMR (allowing an applicant's attorney to cross-check the medicals sent by a defendant to Maximus) rather than Utilization Review, where an applicant really has little control with respect to what is submitted beyond the current PR-2 and RFA.

A statutory Utilization Review is set forth in Labor Code §4604.5(c)(1), limiting certain conservative care modalities to 24 chiropractic visits, physical therapy visits, and/or occupational therapy visits. For a number of years, certain chiropractors have attempted to circumvent this section by claiming that they were primary treating physicians (essentially, "gateway physicians"), and not rendering care but simply making referrals and writing reports. By doing this, they far exceeded 24 dates of service (sometimes by many, many times), but claimed that since there were no "chiropractic treatments", they could see the patient as much as they wanted.

Reviewing the statute, it is noted that the statute does not actually reference the term "treatments", but rather "visits". Thus, we have been taking the position that every time an applicant walks through the chiropractor's door, that counts as a "visit". A case which touches on the subject is a Panel Decision, Romero v. California Pizza Kitchen, ADJ8266885 (January 20, 2016), in which Arroyo Chiropractic was attempting to collect for 86 visits, consisting of mixed chiropractic and physical therapy. The carrier audited and paid for 24 chiropractic treatments, and refused to pay anything further. The trial court took the position that all the treatment rendered was chiropractic, whether described as physical therapy or not, since it was performed by a chiropractor, or under the chiropractor's supervision. Thus, it disallowed the balance of Arroyo's lien. The panel granted reconsideration, finding that even if all the treatment rendered was performed by the chiropractor, that did not necessarily mean that all of the treatment itself was chiropractic; in other words, a chiropractor might be capable of performing physical therapy. The case was remanded for development of the

record with respect to what type of treatment was actually performed, and also noting that lien claimant was not only required to prove that the treatment was actually in the nature of physical therapy, and that it was performed by qualified and licensed personnel, but that it must also show that the treatment was reasonable and necessary.

This does not necessarily resolve the "visit" question with respect to the chiropractor who is not rendering any treatment beyond an alleged evaluation. However, there seems to be some sort of an assumption in this case that, if the chiropractor expects to be paid, he should be doing something by way of his specialty or qualifications.

A case which confirms in applicant's attorneys' minds the absolute worst about Utilization Review is Electronic Waveform Lab v. EK Health Services, in the United States District Court for the Central District of California (March 1, 2016). Lien claimant sued State Compensation Insurance Fund's Utilization Reviewer (EK Health Services) and, presumably, State Compensation Insurance Fund itself, essentially claiming that there was a conspiracy between the two of them to without exception decertify lien claimant's product, an H-wave system. Although under certain circumstances, this unit is an approved modality of care under MTUS, Plaintiff claimed State Compensation Insurance Fund allegedly adopted a blanket policy not to authorize the use of these units, and had instructed its Utilization Reviewer to decertify all requests for the devices. This case simply involves the ability of the lien claimant to state a cause of action in its complaint, so, whether this was true or not was not addressed. The United States District Court found that some of these claims might be actionable. It goes without saying that since Utilization Review is supposed to be an objective evaluation of proposed medical treatment, mandates such as the one described in this complaint, if true, would obviously be improper.

A case which is sure to send a chill through Utilization Reviewers everywhere (assuming it is allowed to stand) is King v. Comp Partners, Inc., 81 C.C.C. 10 (2016), in which the Utilization Reviewer decertified the use of a drug (Klonopin), but did not advise that weaning was necessary, so applicant stopped taking the drug abruptly and as a result began suffering multiple seizures. He essentially sued the Utilization Reviewer for malpractice based not on the medical necessity question (which would have been within the exclusive province of workers' compensation), but based upon a negligent failure to warn of the consequences of an abrupt cessation of the drug. In a published decision by the Court of Appeal, the court found such an action might actually be viable, citing Palmer v. Superior Court, 103 Cal.App.4th 953 (2002) for the proposition Utilization Review has to be conducted by medical professionals who exercise medical judgment and apply clinical standards, and thus further suggesting that a doctor-patient relationship existed between applicant and the Utilization Reviewer. While the court agreed that the question of medical necessity was within the exclusive province of workers' compensation, it felt the failure to warn was not and this could give rise to a breach of the duty of care. The opinion has essentially been erased; however, as the California Supreme Court has granted review.

This does, of course, have applicant attorneys somewhat excited, although the speed with which the California Supreme Court granted review suggests that the case may not survive. If the case does survive, it will certainly create additional, perhaps even insurmountable, burdens on Utilization Review, and applicant attorneys are already talking about the possible application of this case to IMR, and the implications the case has for allowing discovery into all communications between a carrier and its Utilization Reviewer. The Supreme Court is not swift in terms of rendering its ultimate decisions, so it is expected that the final decision with respect to this case will likely not be forthcoming for a couple of years.

With respect to independent medical review, there has been litigation with respect to the timeliness of the decisions. On the panel level, there has been some inconsistency with Gomez v. David Reich Construction, 44 C.W.C.R. 13 (2016) taking the position that the time limits for Independent Medical Review were mandatory and that a failure to abide by those time limits made the IMR decision a nullity, at which point the Workers' Compensation Appeals Board had the jurisdiction to decide with respect to the reasonableness and necessity of treatment (it referenced language in the Court of Appeal case Stevens v. WCAB, 241 Cal.App.4th 1074 (2015) to the effect that the time limits were merely a "directory" and not "mandatory" as dicta). On the other hand, there was Lee v. Quality Timber, 44 C.W.C.R. 12 (2016), which essentially followed Stevens and found the time limits directory.

This conflict now appears to be resolved (at least temporarily) by a published decision from the District Court of Appeal (June 22, 2016), California Highway Patrol v. WCAB, in which the time limits were found to be directory. The court specifically pointed out that it was the policy of the legislature that doctors make medical decisions rather than judges, noting that Stevens v. WCAB, 241 Cal. App.4th 107 (2015) upheld the constitutionality of the IMR system, and further noting that the purpose of the system was to preclude the Workers' Compensation Appeals Board from reweighing the evidence and making a contrary factual determination about medical necessity. The court held that unless a consequence or penalty is provided for the failure to do an act within the time limits prescribed by statute, and the statute relates to an action to be taken by a governmental entity, then the time period is merely directory. It was suggested that the worker's remedy, if it so desired, was to seek a Writ of Mandate in the Superior Court to force the governmental agency to issue a decision, although this would certainly be a cumbersome affair.

III.

MEDICAL TREATMENT: MPNS AND THEIR POTENTIAL ABILITY TO CIRCUMVENT UR

Applicant attorneys seem to be warming up to MPNs. Much of the discussion was with respect to the use of MPNs related to the potential of using the second and third opinion provisions in the statutes as potential methods of circumventing Utilization Review.

The statutory basis for MPNs is set forth in Labor Code §4616, et. seq. They were designed to give employers somewhat more control over medical treatment, conditioned upon medical treatment being readily available at reasonable times, the physician actually had to agree to be in the network, and there had to be adequate information with respect to how to contact the network, as well as the provision of medical access assistance. A certain degree of economic profiling was permitted (Labor Code §4616.1), and every network had to have a continuity of care policy (Labor Code §4616.2). Applicant had to be given a notice of right to change physicians at will within the network (Labor Code §4616.3), and there is an interesting section, Labor Code §4616.6, which provides:

> "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."

The focus of applicant attorneys at this point is Labor Code §4616.3 and § 4616.4, relating to an applicant's right to obtain second and third opinions, and then the requesting of a MPN IMR in the event of a disagreement with respect to diagnosis and treatment. One would think that these methods would be used only if there was a fundamental disagreement

with the underlying treatment recommendations of the primary treating physician, however, applicant attorneys are suggesting that the dispute need not be fundamental; it might almost be specious.

The theory is that, taken together, the two statutes seem to preclude the use of Utilization Review once this appeal process is invoked. The third step in the process (MPN IMR), where the administrative director appoints an independent examiner following applicant's seeking of a third opinion (assuming there is a disagreement with the third opinion) specifically provides that the administrative director adopts the determination of the IMR.

The reference is then made to Labor Code §4616.6 (no additional examinations or reports are admissible to resolve any controversy), with the idea that the controversy started in connection with the resort to the second opinion in Labor Code §4616.3(c). Since a Utilization Review decertification is, in effect, another report, assuming this argument is correct, then the second opinion (or third opinion, or MPN IMR opinion) are the binding words with respect to treatment.

So if the primary treating physician makes a treatment recommendation, even one an applicant likes, he claims a dispute, and moves through the second and third opinion process, thus circumventing Utilization Review.

Additional issues are whether the medical specialties for the second and third opinions must be the same as that of the primary treating physician. In Bautista Avita v. WCAB, 81 C.C.C. 208 (2016), applicant's primary treating physician in the MPN was an orthopedist. He wanted a psychiatric evaluation, so he disputed the orthopedist's treatment, and attempted to obtain a second opinion from a psychiatrist. The panel ruled that applicant was not entitled to seek a second opinion from a psychiatrist where the treating physician was an orthopedist, noting that there was no treatment determination or diagnosis which was being challenged by applicant's request. It was noted applicant's proper remedy was to request a

referral to a psychiatrist from his treating physician and, only if he objected to the doctor's response to the request could he then seek a second opinion from another orthopedist.

In Fernandez v. K-Mart, Case No. ADJ9667092 (January 12, 2016), a panel decision, the panel held that a carrier's refusal to authorize a second opinion doctor within the MPN and instead requiring applicant to follow the Panel QME process, was not a denial of medical treatment so as to allow applicant to escape the MPN. In this case, applicant's primary treating doctor found that applicant was not in need of further treatment and had no permanent disability, but did not render an opinion with respect to applicant's disability status (i.e., MMI). Applicant objected, and requested the second opinion, and the panel held that she was entitled to this, and ordered that it be authorized.

There is still an issue with respect to whether body part disputes can be resolved by the second and third opinion process and the MPN statutes, although there seems to be some concession that the system is not really designed for this.

It does appear that the courts are becoming more accepting of the fact that it is legislative policy to favor MPNs. In Soto v. Sambrailo Packaging, Case No. ADJ9079342 (January 29, 2016), applicant claimed entitlement to treat outside the MPN on the grounds that defendant's alleged failure to make adequate physicians in a specialty available within its MPN constituted a denial of treatment. The trial court agreed, but the panel did not. The surgeon chosen by applicant to treat her declined to accept her, and the panel noted that this fact alone did not allow applicant to bail out of the MPN. The panel held that there were a sufficient number of available physicians within applicant's geographic area with specialties capable of providing applicant's primary care (not necessarily the specialty applicant might want), and the MPN was compliant with the access standards even if the physician with the specific specialty selected by applicant was unavailable.

IV.

INVESTIGATIONS AND RESERVES

The Association, of course, complains that defendants are quick to deny claims based only upon the most cursory of investigations, claiming that the investigative efforts, when they are utilized, are in the direction of denying the claim, rather than finding reasons to accept it. The Association references Regulation 10109, which requires a claims administrator to conduct a reasonable and timely investigation upon receiving notice or knowledge of an injury, and further providing the investigation may not be restricted to preparing objections or defenses to the claim, but must fully and fairly gather pertinent information. It is also noted that the investigation may not be restricted to the specific benefit claimed, if the nature of the claim suggests other benefits might also be due, or if the claims administrator receives later information, not covered in the earlier investigation, which might affect benefits due (and in connection with this latter provision, there is a suggestion that it might well have reference to a situation where a specific body part is admitted, and later body parts later come into play).

Agreed, rules do require that a reasonable investigation be conducted both with respect to compensability, as well as reasons why the claim was not industrial. Thus, in Hernandez v. Geneva Staffing, 79 C.C.C. 682 (2014) an en banc Appeals Board decision, it was held that an employer has a duty under Labor Code §4600 to investigate an applicant's need for medical care, even if the information the employer receives with respect to the need for care is ambiguous (this decision did not directly involve a RFA, but it does suggest that an employer might be at risk for refusing to consider a request for medical care simply because the physician has not submitted the RFA). It works both ways, of course, an

employee cannot complain that an employer investigated his background to the extent that this investigation was relevant to the claim the employee was making. Mansilla v. WCAB, 66 C.C.C. 937 (2001).

In fact, the investigation in connection with the defense of the claim may well become more sophisticated. There does seem to be some concern with respect to the use of drones in connection with sub rosa. Although the FAA does not regulate model aircraft based on recent regulation, almost certainly a hobby type aircraft which would be used for a commercial purpose would not fall within the definition of a model aircraft, and would be regulated as a commercial aircraft. Any investigator using such an aircraft would have to be mindful of the FAA's general operating and flight rules with respect to careless or reckless operation, and would almost certainly have to be mindful, as well, with respect to the privacy provisions set forth in Civil Code §1708.8 (essentially, the paparazzi statute, although claims investigations would appear to be exempted where there is an articulable suspicion of wrongdoing).

This topic properly naturally relates to the topic of setting reserves, which essentially estimates of the amount of money it will take to cover the costs of a claim. While the initial reserve is not set in stone, and the reserve can change from time to time, ideally an adequate reserve (not too high or too low) is to be estimated at the outset, which will carry forward to the conclusion of the case.

Applicant's attorneys are, of course, extremely interested in learning how a case is reserved, and the amount of that reserve, feeling that would make case resolution much easier for them. Consensus among the panel (some of whom were formerly employed in the insurance industry) is that this information is privileged, and will never be voluntarily surrendered in response to a subpoena or notice to produce.

The process involved in the setting of reserves may become relevant in a bad faith case, but it is difficult for us to see how an applicant would be able to make such a claim against a workers' compensation insurer. There are some limited cases where the employer has made such a claim, based on over reserving.

V.

RATING OF THE SPINE AND APPLICATION OF ALMARAZ/GUZMAN

This section involves several elements. Although the body part involved is primarily the spine, this section will also deal, in part, with the use of vocational testimony as well as the application of rebuttal principals set forth in what is commonly known as Almaraz/Guzman.

Basic rating principals with respect to the spine (Chapter 15) specify the use, first, of the DRE Method and, if not appropriate, then the range of motion method. A very significant portion of all back disabilities are going to be rated one way or the other. DRE is the preferred method, although, in sort of a mini Guzman approach, there does not seem to be too much resistance to alternatively rating the back by way of both methods, and choosing the one which yields the highest disability.

The Almaraz/Guzman method of rebutting a strict AMA rating comes into play when the strict rating does not accurately reflect the applicant's impairment. The term "accurate" is not really defined anywhere, and applicant's attorneys disagree with the idea that a case must be "complex and extraordinary" in order to justify a rating by analogy. The consensus appears to be that an accurate rating should reflect the relationship between the industrial injury and the permanent effects and objective medical condition or diagnosis has on an individuals ability to perform activities of daily living. If a physician believes this to be the

case, he must then explain how and why the alternate rating is more accurate than the strict AMA Guides impairment rating and, in the case of an analogy, explain why a particular table more accurately describes the impairment. This certainly involves a description of both impairment ratings, and a comparison of them in connection with applicant's ability to perform activities of daily living.

Various methods of alternative rating are as follows:

(a) With respect to the spine, reference is made to rating by reference to the corticospinal tract (the nerves extending from the brain into the spinal cord, the primary function of which is the transmission of signals for movement). Certain clinical signs, as well as bladder and/or bowel incontinence are symptoms of actual impairment with respect to this area, although it may form a more acceptable basis in analogy in connection with spinal cases, since it is within the same chapter.

The same probably does not apply to the conversion chart contained in figure 15-19, the only purpose of which appears to be to allow a conversion in a spinal case from a whole person impairment to a regional impairment. Applicants argue for its use in connection with the measurement of the loss of function in various regions of the spine which, to a large extent, introduces a subjective element where a general loss of function opinion is submitted by the doctor (a true loss of function would almost certainly have to take into consideration the myriad of findings from the clinical evaluation, and measure them together). A few cases have accepted this method of rebuttal [Laury v. R and W Concrete (2011)], but most have not [Leon v. RF Development (2011)]; Bagdasaryan v. County of Los Angeles (2013); and Hobbs v. County of Los Angeles (2015), suggesting that the rebuttal was a misuse of the figure (which had a specific purpose), further suggesting that this type of rebuttal came very close to mimicking the work restrictions which were the basis of the 1997 schedule.

(b) In connection with multiple disabilities, arguing that the synergistic loss can justify adding separate impairments instead of using the combined value chart. This probably works better in a situation where the multiple disabilities are completely disparate (for example, an internal medicine disability and an orthopedic disability) rather than when dealing with multiple disabilities of the same nature (orthopedic) or, indeed, in the same body region. See Kite, 78 C.C.C. 213.

(c) Reference to other chapters in the AMA Guides. This is within the four corners of the AMA Guides, but if an applicant attempts to go too far afield, then it could be argued that it is a fishing expedition for a rating which is more subjectively pleasing to an applicant. There has been some success in using Table 6-9 relating to hernias as analogies to back disabilities [Graham v. Pepsi (2011); Cortez v. State of California (2014)], but of the analysis has also been rejected on the grounds that this analogy mimics the work restrictions of the 1997 schedule. Rockford v. Long Beach (2012). Johnson v. Cal Trans (2013), a panel decision, rejected an attempt to use Table 6-9 on the basis that the DRE method implicitly already accounts for lifting limitations.

Basing an impairment on altered gait in a spinal case has met with more success, especially where an assistive device is utilized. Fitzsimmons v. Scotts (2011); Phaeffle v. San Mateo (2013); Peiper v. FPI (2013).

(d) The effects of medication. Quite frankly, we do not see as much of this as we would expect. Applicants loaded up with the powerful narcotics and/or psychotropics that many of their free choice treating doctors feel an appropriate method of dealing with alleged pain are probably not in much of a position to go to work (even drive a car). We are actually somewhat surprised that this factor does not play a much more significant role in an Almaraz/Guzman analysis.

(e) Vocational factors. The use of vocational experts has been tightened up somewhat by Contra Costa Co. Vs. WCAB (Dahl), 80 C.C.C. 1119 (2015), in requiring that vocational evidence is not really relevant with respect to issues of permanent partial disability, only with respect to issues of pretty much permanent removal from the open labor market (at least in connection with the LeBoeuf approach, which we think would be the most common). Thus, this type of evidence is pretty much going to be limited to cases where an applicant is claiming to be totally disabled. In Wright v. Michaels, 2015 Cal. Wrk. Comp. P.D. Lexis 455, an applicant was found to be 100% totally disabled on a variety of factors, including the medical evidence and vocational testimony. The vocational expert found that applicant incurred a total loss of earning capacity based on the synergistic effect of the functional limitations set forth by the medical evaluators, but the medical evaluators were also rendering opinions that the applicant was most likely too disabled to work.

Again, we would take the position in a case involving a vocational issue that it is not enough to present only vocational testimony on the issue of total disability; we think there must be medical evidence of total disability as well (not necessarily based upon the strict rating but at least medical opinion that the applicant will likely not be able to return to the labor market).

VI.

APPORTIONMENT

Quite frankly, little by little, applicants appear to be making more inroads with respect to apportionment. When the new apportionment statutes were interpreted in connection with SB 899, the defense obtained some good law, particularly as it related to the effect of underlying, perhaps previously non-disabling, pathology. However, we have noticed a trend that seems to be minimizing these conditions, which advocates argue that, under the AMA Guides, should not really be a basis for apportionment. In referencing page 383 in Chapter

15, it is noted that there are physiologic and structural impairments which actually may be the result of common developmental findings, and they are normally found in people of certain ages, with the admonition that the presence of these abnormalities does not necessarily mean the individual has an impairment due to an injury. The courts are paying much more attention to the physician's obligation to explain the how and why of apportionment, and applicants increasingly look into cases such as Kopping v. WCAB, 71 C.C.C. 1229 (2006), for the idea that, to obtain valid apportionment, there must be a true overlap of disability. Thus, in APC/Vancom, Inc. v. WCAB, 79 C.C.C. 1329 (2014), the relatively common method of apportioning a consequential psychiatric injury (in the same manner as the primary orthopedic injury) was rejected, the panel stating that the opinion was not substantial evidence because the psychiatric evaluator did not explain why the apportionment was the same (this case was a true injustice, as a number of factors were noted in Chairwoman Caplane's dissent which suggested that, if not grounds for apportionment, there was certainly reason to look at the very substantial psychiatric rating with suspicion).

The specific disabilities identified in Labor Code §4662 (certain injuries to the eyes, paralysis, serious brain injury, loss of use of both hands) are considered 100% disabling, without apportionment. That does not mean, however, that the court ignores a prior condition without which the Labor Code §4662 disability would not exist. In Kirkwood v. Workers' Compensation Appeals Board, 80 C.C.C. 1082 (2015), applicant sustained an apparently disabling injury to her right arm which substantially impaired her use of her right hand. She had previously had a non-industrial amputation of her left arm. The trial judge found that the industrial injury resulted in the loss of use of both hands and awarded her a 100% disability award. In granting reconsideration, the panel held that the industrial injury had to be with respect to both of the involved body parts (in other words, an industrial injury to both hands), so, in this case, Labor Code §4662 did not apply. This case also involved the use of vocational testimony and, as an alternative basis for his decision, the trial judge relied

upon the vocational expert who testified that applicant's overall disability precluded her from the open labor market. The panel again rejected this basis for decision, noting that the vocational expert disregarded the impact of applicant's pre-existing, non-industrial amputation in analyzing her diminished future earning capacity and vocational feasibility.

While good vocational testimony can certainly be dangerous in a case, a vocational expert must take into consideration the medical apportionment in a case; otherwise his opinion does not constitute substantial evidence. Borman, 218 Cal. App. 4th 1137.

The Association argues that there is no case which compels the vocational expert to follow the medical apportionment in a case, only consider it, reasoning that, as long as the vocational expert "considers" the apportionment, he can reach a different conclusion with respect to market feasibility than the medical expert. We are skeptical about this. We believe that the vocational evidence must be consistent with the medical evidence. If applicant's overall, medical disability is a result of both industrial and non-industrial impairments, we have some difficulty seeing how the vocational expert's opinion, which has to be based upon the medical disability, can reach a different conclusion with respect to apportionment.

An example used by the Association panel is an applicant with legitimate, 25% apportionment, who the vocational expert believes would require four substantial rest periods during the course of a working day. By applying the apportionment, the applicant needs three industrial rest periods, which is still the equivalent to part-time work, and thus total disability. However, unless the medical evaluator is finding the need for these rest periods, at this point, we don't buy it.

The second, "catch all" part of Labor Code §4662 (total disability according to the fact) is subject to apportionment. In Enriquez v. County of Santa Barbara, applicant suffered significant psychiatric disability causing him to become 100% disabled, although 40% of his disability was considered non-industrial. Rejecting his claim that the psychiatric injury constituted a "brain injury" for the purposes of Labor Code §4226, the panel found that apportionment of applicant's disability was proper. In Valenzuela v. State of California, 2013 Cal. Wrk. Comp. P.D. Lexis 401, the panel stated that a finding of permanent total disability in according with the fact pursuant to Labor Code §4662 does not preclude apportionment of permanent disability between industrial injuries as described in Benson, since 100% disability in accordance with the fact is not a conclusively presumed permanent total disability, which would otherwise preclude apportionment.

A very serious problem is developing, however, in connection with compensable consequence-type injuries/disabilities arising out of a primary industrial injury (or series of industrial injuries). The cases which are getting attention involve psychiatric and internal medicine type disabilities, although we assume that pain syndromes could easily be involved as well. Essentially, these cases involve a rejection of the so-called "pass through" apportionment, which many evaluators have traditionally used (apportionment with respect to the consequential disability follows the apportionment with respect to the primary disability). In Caires v. Sharp Health Care, 2014 Cal. Wrk. Comp. P.D. Lexis 145, the panel stated:

> "Furthermore, Dr. DeBoskey did not explain why the permanent disability resulting from applicant's psychiatric injury should be apportioned in accordance with permanent disability resulting from the orthopedic injury. While it may be intuitively appealing to apportion permanent disability pertaining to different body

> parts in identical fashion, a medical evaluator in a particular field is tasked with parceling out industrial and non-industrial causation of permanent disability for the body parts or body systems that are within his or her area of expertise."

In Jackson v. County of Los Angeles, 2013 Cal. Wrk. Comp. P.D. Lexis 558, the agreed medical examiner in psychiatry refused to apportion in the same manner as the agreed medical examiner in orthopedics, and the panel held that the psychiatrist was not required to follow the orthopedist's apportionment.

The problem with this is the effect on the rating. Even though defendant may have obtained an orthopedic apportionment, if the evaluator of the secondary disability finds that it is speculative to attempt to apportion with respect to that disability at all (causation is inextricably intertwined), this pretty much destroys the orthopedic apportionment, and the result is a combined Wilkenson type rating.

In Fields v. City of Cathedral City, 2013 Cal. Wrk. Comp. P.D. Lexis 103, the panel held applicant was entitled to a single, combined award of permanent disability, when the opinion of the agreed medical examiner in internal medicine was that the internal medicine aspect of disability was so intertwined that the injuries could not be rated separately. At the time of his deposition, the internist finally agreed to follow the apportionment of the orthopedic AME (reluctantly) when told by the defense attorney that he "had to put a number on it," but it was found that this was just speculation.

Similarly, Northrop Grumman Systems Corporation v. WCAB, 80 C.C.C. 749 ended up combining the permanent disability from three separate injuries when the opinion of the psychiatric examiner was that an applicant's psychiatric disability was inextricably

intertwined. The panel stated that the analysis regarding causation of injury is not the same as causation of permanent disability.

Also note Dawson v. San Diego Transit, 2015 Cal. Wrk. Comp. P.D. Lexis 745, where applicant had an accepted cumulative trauma injury to her right shoulder and was involved in an auto accident on her way to treatment which injured her spine and caused pretty much complete paralysis. Although there were non-industrial aspects of her shoulder disability, the spinal injury trumped it all under Labor Code §4662, which created an irrebuttable presumption of total disability on an industrial basis.

There are two types of apportionment referenced in the Code, Labor Code §4663 apportionment, which relates to prior conditions, and Labor Code §4664 apportionment, which relates to prior awards. In so-called "safety" cases (in general, involving most police and firefighters), there are statutory presumptions of industrial injuries with respect to certain body parts (the spine, the heart), and these statutes generally contain "non-attribution" clauses (and there is one in Labor Code §4663 as well) which preclude non-industrial apportionment. Delia v. County of Los Angeles, 2010 Cal. Wrk. Comp. P.D. Lexis 282. In Lee v. State of California, 2010 Cal. Wrk. Comp. P.D. Lexis 485, applicant had a back injury which was compensable under the "duty belt" presumption, so it was found that a Benson apportionment from a prior back injury was not permitted by virtue of the anti-attribution clause, and there could be no apportionment. See also Stephens v. City of Los Angeles, where applicant established five separate cumulative traumas which were deemed presumptively compensable but, because of the anti-attribution clauses, Benson apportionment as between the five injuries was not permitted, and applicant was awarded a combined permanent disability of 89%, without apportionment.

Labor Code §4664, which involves prior findings of permanent disability, may allow some apportionment in a safety case, but overlap is required, and the Board is apparently taking a rather narrow view with respect to what constitutes overlap. Thus, in Kudelka v. City of Costa Mesa, applicant, a firefighter, had received a prior 36% award for heart trouble which involved an aortic valve replacement. He sustained a second presumptively compensable cumulative trauma injury to his heart, in the form of hypertensive heart disease. The panel found that Labor Code §4664 did not apply, since, although the heart was involved in both cases, the cardiac injury in this case (hypertensive cardiovascular disease) was a distinct impairment from the prior heart disability (aortic valve disease).

VII.

DEATH CLAIMS

If an employee dies at work, there is no general presumption that the death is industrially compensable, without some basis in fact. Hurt v. Kaiser Foundation Hospital, 29 C.W.C.R. 221 (2001). That being said, if an employee is found dead on the job site, an employer is going to have a tough time with the defense of such a case. There is a presumption or inference that an employee's death arose out of his employment where the cause of death is unknown and employee died on the job. Clemmens v. WCAB, 33 C.C.C. 186 (1968).

A compensable death must have been caused by the employment, or by an industrial injury (Labor Code §3600), but the courts have interpreted proximate cause being "contributory cause" (Madin v. IAC, 46 Cal. 2d 90 (1956), and this is a very low bar.

A shining example about just how low this bar is is a California Supreme Court case, South Coast Framing v. Workers' Compensation Appeals Board, 80 C.C.C. 489 (2015), where applicant died of a drug overdose. He was taking six different drugs, four prescribed by his industrial doctor for pain, and two by his personal doctor, apparently in connection with sleep problems which may have pre-existed the industrial injury. The medical-legal evaluator felt that the cause of death was the additive effect of the drugs from his personal doctor, and that the industrial prescriptions did not contribute to applicant's death. After a lot of brow beating during his deposition, he conceded that contribution of the industrial medicines was not 0%, but it certainly was not substantial, and that was enough for the court, which stated that the only thing required is that employment be one of the contributing causes without which the death would not have occurred. It noted that apportionment does not apply in death claims, and that in the workers' compensation system, the industrial injury need only be a contributing cause of death (the doctor's testimony to the effect that "it is not zero" was what did it).

In response to the defense argument that employment provides only a stage, there is the so-called neutral risk doctrine, which is related to the presumption or inference which arises when the cause of death is unknown. This doctrine generally applies to a crime scene at work, where an employee's murder arises under mysterious circumstances with no basis for finding personal motive. See Getro Cash & Carry Holdings v. WCAB, 73 C.C.C. 698 (2008); Lee v. WCAB, 77 C.C.C. 297 (2012).

If there is evidence that the murder arose out of personal animosity (such as revenge for an affair), then there is a basis for saying that the workplace was simply a stage, and the death was non-industrial. Carpio v. WCAB, 77 C.C.C. 554 (2012).

With respect to suicides, the general rule is that this is not a compensable death where the employee wilfully and deliberately causes his or her own death (Labor Code §3600). The exception, of course, is whether it can be shown that the suicide act was actually a consequence of the industrial injury [disability, coupled with suicidal depression, Donovan v. WCAB, 47 C.C.C. 1411 (1982); Chu v. WCAB, 61 C.C.C. 926 (1996)].

Although drug overdoses are sometimes considered in the context of suicide, quite frankly, they really are not. Suicide has death as its intended result; most people dying of drug overdoses in workers' compensation did not have that result in mind.

With respect to time limits, the general rule is that the application must be filed within one year of date of death, although there is an overall general statute that most proceedings cannot be commenced in excess of 240 weeks from date of injury (if the injury itself did not immediately cause death). Labor Code §5406.

After compensability, issues generally arise with respect to dependency. There are persons who are conclusively presumed to be wholly dependent (minor children and the spouse at the time of death who earns $30,000.00 or less a year), but that does not necessarily preclude others from attempting to prove complete dependency (marriage is not necessarily required). It is generally in the defendant's interest in connection with an industrially compensable death to find some sort of dependent; otherwise, the Death Without Dependent Unit collects the equivalent of a total dependency death benefit.

Despite the statutory maximums, those maximums may be exceeded in the event of minor children (or incompetent dependents) (Labor Code §4703.5). There is still some predictability here, except for an odd doctrine to the effect that a workers' compensation judge can increase the temporary disability rate up to maximum based upon financial need.

Foodmaker v. WCAB, 60 C.C.C. 124 (1995). Death benefits are paid at the temporary disability rate and, what this means, is that if a decedent's wages are such as to result in a temporary disability rate of less than maximum, a workers' compensation judge, based upon a finding of need, can increase those payments up to the maximum rate, if necessary. While this is not necessarily problematic where a defendant is dealing with a fixed death benefit, it becomes very problematic in dealing with a very young minor child, who is paid until age 19.

VIII.

MEDICAL LEGAL EVALUATIONS

The statutory basis for medical legal evaluations is set forth in Labor Code §4060, et seq. The three basic statutes are Labor Code §4060 (AOE/COE evaluations), §4061 (issues relating to permanent disability and future medical care), and §4062 (anything not covered by Labor Code §4061 except for statutory Utilization Review). Labor Code §4062.1 and §4062.2 set forth the basic rules for obtaining QME Panels in unrepresented and represented cases. In connection with represented cases, the parties are no longer required to attempt to agree upon an Agreed Medical Examiner, but if the parties do reach an agreement on an Agreed Medical Examiner, there can be no unilateral withdrawal from that agreement without good cause. Castroena, 2014 Cal. Wrk. Comp. P.D. Lexis 643.

There is still a lot of gamesmanship with respect to the obtaining of panels, and this will likely continue as long as panels remain the method of gaining medical-legal evaluations. The initial submission of the QME Form 106 (the first panel request) is done electronically, and the resolution of disputes with respect to online panel requests is left to the Workers' Compensation Appeals Board. A number of applicants' attorneys feel that the method of dealing with an unfavorable panel opinion is to attempt to disqualify the doctor

in some manner, so that a new panel can be requested. There is also talk about simply filing another Application, alleging a slightly different injury, so that another panel can be obtained. One of the panelists, Judge Szelenyi, simply suggested that, if another panel is desired (presumably in another specialty), the parties should simply file a petition with the Board, but that does not answer the question of the attorneys who want to dump the previous panel doctor in the first specialty.

Applicant attorneys are looking at the Navarro case (42 C.W.C.R. 61), which stands for the proposition that a claim filed after the selection of the initial QME entitles the parties to a new panel.

Related to this is Chanchovac, 2015 Cal. Wrk. Comp. P.D. Lexis 516, standing for the proposition that a co-defendant, coming into a case following the assignment of a panel is entitled to request its own panel. Thus, the original idea behind the requirement that panels be used (reduce the proliferation of medical legal evaluations) seems to be somewhat evaporating.

Attempting to obtain a replacement panel may still be difficult. Once a QME has rendered an opinion with respect to a matter, the Workers' Compensation Appeals Board seems to favor keeping them on, despite rule violations, assuming those rule violations are not serious. Garcia, 2014 Cal. Wrk. Comp. P.D. Lexis 57; Giron, 2016 Cal. Wrk. Comp. P.D. Lexis ___.

One last note relates to the hidden attorney, that is, the unrepresented applicant who is actually being assisted by an attorney behind the scenes. The defendant becoming aware of this can litigate the issue with respect to whether applicant is really represented. Johnson, Case No. ADJ4617702, which may give the defendant the opportunity to claim that they have benefit of Romero, 72 C.C.C. 824 (2007) (if an applicant becomes represented prior to the examination on the unrepresented PQME track, the matter switches to the represented track).

IX.

THE REST

A troubling case for the defense is Zuniga v. County of Los Angeles, 2014 Cal. Wrk. Comp. P.D. Lexis, 549, where a deputy sheriff claimed what appeared to be concurrent orthopedic injuries and cardiovascular injuries. He ran through his Labor Code §4850 and temporary disability entitlements, initially with respect to the orthopedic disability, but then incurred an additional period of temporary disability, apparently in connection with the internal medicine condition. The Panel found that because the periods of temporary disability related two distinct types of injury (orthopedicand internal) applicant was entitled to maximum periods of temporary disability with respect to each.

With respect to lien claimants, in Valadez v. Coast Plating, 2016 Cal. Work Comp. PD Lexis 11, a lien representative appeared at the lien conference, at which time the matter was continued to a trial, but they did not show up at the trial. They claimed that they were not given notice of the trial, but the Panel found they had actual notice of the trial by virtue of their presence at the prior lien conference, so the liens were dismissed.

Borbeck v. Ace Building Maintenance involved a Compromise and Release which provided that the defendant would "pay, adjust and/or litigate liens", which was approved. Apparently unbeknownst to the defendant, the applicant had been collecting temporary disability and state disability benefits at the same time, with the result being that the Employment Development Department had a $34,000.00 lien. It was held that the lien provision in the Compromise and Release required the defendant to reimburse the Employment Development Department.

Chorn v. WCAB, 81 C.C.C. 322 (2016) is the state court equivalent of Angelotti, the lien claimant complaining that the imposition of filing fees imposed an unconstitutional burden on the ability of applicants to obtain care. The court disagreed, stating the legislature has nearly unbounded power to enact workers' compensation provisions so long as it determined such action to be necessary to the effectiveness of the system of workers' compensation, and it felt that way in enacting the filing/activation fees.

There are a pair of psychiatric cases relating to what constitutes a sudden and extraordinary event for the purpose of allowing a psychiatric injury claim where an employee has not been on the job for more than six months. Travelers Casualty and Surety Company v. WCAB, 81 C.C.C. 234 (2016), apparently stands for the proposition that slip and fall type injuries will not be considered sudden and extraordinary events, pretty much as a matter of law. On the other hand, in Larsen v. Securitas Security Services, 44 C.W.C.R. 111 (2016), a Panel held that a security guard being blind sided by an automobile was a "violent act", relying on the Black's Law Dictionary definition, which defines the word violent as relating to, or characterized by, strong physical force.

Finally, a general special employment case which did not involve CIGA was Twin City Fire Insurance v. WCAB, 81 C.C.C. 299 (2016). In this case, the general contractor engaged a painter without a contractor's license to perform work, "borrowing" the license of a subcontractor, apparently in exchange for a promise of additional jobs. The general contractor paid the subcontractor, which deducted a fee for its services, and the subcontractor then remitted the balance to the painter. The court held general employment followed payroll, so the subcontractor was deemed the general employer, and the general contractor was deemed the special employer, since the work was being performed for it.

X.

CONCLUSION

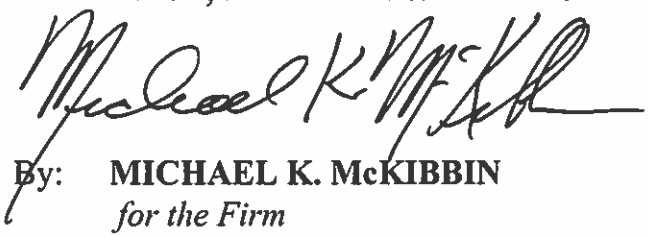
From the standpoint of applicant's attorneys, things seemed to be settling down. They have apparently developed techniques for dealing with the reforms which became effective with Senate Bills 899 and 863, and the courts appear to be looking for, and finding, ways to limit defenses such as apportionment.

Although this system has never been slanted in favor of defendants, the Senate Bill 899 and 863 reforms certainly made things more advantageous for defendants than they had been in the past. For a brief while (following SB 899), permanent disability benefits were truly limited, but through the use of *Almaraz/Guzman* and vocational experts, as well as the use of compensable consequence type injuries, those benefits have broadened. At this point, it does appear that the pendulum may be starting to swing back in favor of the applicant's bar.

We hope you have found this report to be helpful and of interest, and if you would like any presentations with respect to the issues presented, or anything of interest to you, please let us know.

Very truly yours,

BENTHALE, McKIBBIN & McKNIGHT



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