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THE DEFENSE PERSPECTIVE AND OBSERVATIONS OF THE CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION 2017 SUMMER CONVENTION

2017 SUMMER CONVENTION OF THE
CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION
JUNE 22 - 25, 2017

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TO OUR CLIENTS:

I.

INTRODUCTION

The following is a report of our observations with respect to the California Applicant's Attorneys 2017 Summer Convention, which took place June 22-25, 2017. The immediate observation is that applicant's attorneys appear to becoming more and more comfortable in dealing with now longstanding reforms brought about by Senate Bills 899 and 863. In fact, there are now a large number of younger attorneys who have never practiced workers' compensation law under any other system, and are unfamiliar with the system as it existed under the 1997 (and prior) permanent disability schedules.

What has developed under the reforms are increasing claims with respect to compensable consequences of the primary injury. There have been limits on some of these consequences (notably, psychiatric, sexual dysfunction, and sleep dysfunction claims), but there is still a proliferation of these claims.

Hotly litigated issues at this point relate to the fields of apportionment, with a growing interest in vocational evaluations as a possible method of defeating apportionment. Although applicant attorneys continue to complain about the system, it is our assessment these complaints are at or about the level they were prior to the reforms.

There are only five commissioners at this time (they are two short, including the chairperson). This will more than likely delay things in terms of issuance of opinions (in

connection with the sample opinions provided by the commissioners for their panel, they are saying there may be a significant number where reconsideration was granted for "further study.") It is possible this is happening because the Commissioner's office is short staffed.

Over the years, we also note that there has been more and more reference and reliance placed upon WCAB panel decisions (as opposed to precedential decisions such as those decided by the WCAB *en banc*, or published opinions of the Court of Appeal). These panel decisions are not binding on anyone, but from the standpoint of trial judges, and in the absence of some sort of binding precedent, we think the judges will be looking to these panel decisions for guidance, and following them. Many of the cases which will be referenced in this booklet are such decisions.

II.
DISABILITY AND IMPAIRMENT

As a practical matter, this and the two sections following are being separated simply for the purpose of convenient reference. In large part, these sections tend to bleed into each other, and overlap.

For reasons which will be seen in the later sections, applicant attorneys are focused on the difference between disability and impairment (and it is a difference of which we should all take note). The AMA Guides defines an impairment as a medical determination with respect to loss, loss of use, or derangement of any body part, organ system, or organ function. It refers to an alteration of a body part or system from its normal, healthy functioning. An impairment percentage (i.e., either a regional or whole person impairment) are consensus-derived estimates that reflect the severity of the medical condition and the degree to which the impairment decreases an individual's ability to perform common activities of daily living, excluding work. [AMA Guides, Chapter 1, pages 2, 4 (5th Edition)].

The Labor Code does not define the term disability. However, the AMA Guides defines disability as an alteration of an individual's capacity to meet personal, social, or occupational demands, or statutory or regulatory requirements because of an impairment. A disability determination also includes information about the individual's skills, education, job history, adaptability, age and environment requirements and modification. AMA Guides, Chapter 1, page 8.

Applicant's attorneys continue to argue that the AMA Guides were never intended to be used as a direct measure of disability for the purposes of awarding compensation (referencing page 9). Thus, it is for this reason that applicant's attorneys teach that greater consideration must be given to the compensable consequence of medical conditions which develop as a result of either the initial industrial injury, or the treatment which is rendered in connection with that injury.

In essence, applicant's attorneys believe that there are four basic methods of establishing permanent disability at this time: (a) the standard method, which is by use of the Permanent Disability Rating Schedule set forth in Labor Code §4661 or §4661.5; (b) the Guzman approach with respect to rebutting one or more segments of the standard rating formula; (c) the Ogilvie/LeBoeuf vocational evaluation approach; or (d) use of Labor Code §4662 (presumed total disability, argued by reason of the body part involved, or "by the fact."

III.

RUBUTTING AND DISREGARDING THE SCHEDULE

We are reminded that there are a number of different ways of circumventing the statutory permanent disability rating schedule set forth in Labor Code §4660 and/or §4660.1. These are by way of the so called Guzman approach, vocational evaluation, or total permanent disability either in connection with the body parts described in Labor Code §4662,

or according to the fact [Labor Code §4662(b)].

One target related to the combined value chart (CVC), which a number of the panelists assert makes it impossible to prove permanent total disability. The intended purpose of the CVC was to eliminate overlapping double recovery, but the panelists claim that its true function is to eliminate 100% cases.

First of all, that is not really true since even in the case of a single injury which takes a whole person impairment of 72% or more, the 1.4 multiplier in Labor Code §4660.1 by itself will bring the rating over 100%. Secondly, multiple injuries which result in rated disability in the 90% range will also combine to result in permanent total disability. Admittedly, it is very difficult, but it is not impossible.

There is some claim by several of the panelists that after January 1, 2013 the statutory changes with respect to the permanent disability schedule deprived the administrative director of his authority to adopt the CVC as a part of the schedule. We have not seen any cases raising this issue, but since it is being advocated by several of the prominent panelists, we are likely to see it at some time in the future. However, it is clear that, like the rest of the schedule, the CVC is rebuttable (it is prima facie evidence of disability, and presumptively correct, Gonzales v. Adams Campbell Company, 2017, Cal. Wrk. Comp, P.D. LEXIS 113 (2017), but it is rebuttable). Alternative methods include a suggestion the old multiple disabilities table be used (the few cases that have considered this have not favored it), as well as the use of addition (rather than the compressing effect of combination) (a proposal which a judge might be more receptive in a case involving different regions of the body).

The one attempt we have seen to use the Multiple Disability Schedule, which failed is Foxsworthy v. Department of Parks and Recreation, 45 C.W.C.R. 12 (2017), where the panel reasoned that under Labor Code §4660(c), the Combined Values Chart of the 2005

Permanent Disability Rating Schedule applied absent overriding reasons to use a different method of accounting for multiple impairments. The panel noted that the Combined Values Chart is rebuttable, although presumptively correct. We are also wondering if use of the Multiple Disability Table would be considered an attempt to utilize a permanent disability schedule (i.e., the 1997 Permanent Disability Schedule) which is no longer valid, and the use of which has been disapproved by Guzman.

In Athens Administrators v. W.C.A.B. (Kite), 78 C.C.C. 213 (writ denied), it was held that adding disabilities (as opposed to using the CVC) under a Guzman type analysis could be considered a more accurate method of obtaining an accurate disability rating, if the facts warranted this.

In Labor Code Sections 4660 (prior to January 1, 2013) and 4660.1 (after January 1, 2013), the Permanent Disability Schedule thus established is considered presumptively correct. Gonzalez v. Adams Campbell Company, 2017 Cal. Wrk. Comp. P.D. Lexus 113 (2017). It is well-established, however, that this presumption is rebuttable. Milpitas Unified School District v. WCAB (Guzman), 187 Cal. App. 4th 808 (2010). Guzman stands for the proposition that use of the AMA Guides is mandatory, but the scheduled rating can be rebutted utilizing the four corners of the Guides. Thus, examples of different methods of doing this (as long as the rationale and method was adequately explained), were by using a combination of both the strict rating for range of motion loss and the more subjective rating for grip loss in an upper extremity case, Barajas v. Fresno Unified School District, 2012 Cal. Wrk. Comp. P.D. Lexus 7 (2012); rating by analogy to a gait derangement with respect to a foot and heel injury where, under the strict guidelines, there would be no impairment, The City of Sacramento v. WCAB Cannon), 222 Cal. App. 4th 1360 (2013) (the "complex or extraordinary" standard should not be utilized to restrict a physician's expertise, but should be read to reflect the ability of a physician to rate an impairment by analogy within the four corners of the Guides, where strict application of the Guides does not accurately reflect the

impairment being assessed); rating by analogy by the use of arousal disorders and emotional or behavioral disorders under the Guides for the purpose of assessing impairment for fibromyalgia, a condition which is not addressed in the Guides at all, Mrozek-Payne v. S.C.I.F., 40 C.W.C.R. 122 (2012).

Utilizing impairment within the four corners of the AMA Guides, Fifth Edition (as prescribed by statute) is mandatory however. Thus, an opinion based upon the Sixth Edition of the AMA Guides does not constitute substantial evidence as a matter of law, since the opinion rests upon an incorrect legal premise, that being that Guzman allows a rating outside of the four corners of the Fifth Edition of the AMA Guides. Frazier v. State of California, Case #ADJ8008017 (Panel Decision, October, 2013).

Rather than rebutting the individual elements of the schedule as it relates to a particular body part, one Guzman approach is to attempt to rebut the method of combining disabilities (the Combined Values Chart). Several different methods of doing so are advanced, including use of the old multiple disability table in effect prior to 2005; simply adding the disabilities, instead of compressing them (as the chart does), or even utilizing a multiplier (this we have not yet seen).

The second approach was followed in Miller v. Troer & Graff, 2016 Cal. Wrk. Comp. P.D. Lexus 667 (2016), in which a determination that the most accurate way of calculating applicant's overall permanent disability was by adding his disabilities rather than combining them was upheld.

Use of Labor Code §4622 is not really considered a rebuttal, but simply a statutory alternative for the Permanent Disability Rating Schedule. The focus at the convention was primarily on Labor Code §4622(b), which is total disability according to the fact. This is illustrated in Anaya v. WCAB, 2016 Cal Wrk. Comp, P.D. Lexis 314 (2016) where applicant

suffered a pulmonary disability and compensable consequence injuries, which rated to 93%. Following trial, the judge awarded permanent total disability, based upon the opinions of two of applicant's treating physicians and the Agreed Medical Examiner that applicant was incapable of returning to the open labor market (basically, a Le Beouf finding). The court explained that Sections 4660 and 4662 offer different paths to disability, and that the standards set forth in Labor Code §4660 do not apply to determinations made pursuant to Section 4662.

Similar is Truesdell v. Von's Grocery Company, 45 C.W.C.R. 67 (2017), where it was held that a medical determination of inability to compete in the open labor market can, standing alone, rebut the 2010 permanent disability rating schedule. (Applicant had an unsuccessful back surgery and failed back syndrome it was found by the Agreed Medical Examiner to be 100% permanently disabled and unable to compete in the open labor market). In connection with an unequivocal medical determination to this effect, no vocational evaluation is required (and, using Anaya's rationale, this is not really a rebuttal of the permanent disability rating schedule, but a determination of permanent disability under a completely different statute, Labor Code §4662).

There was a great deal of attention given by a number of the panels to the impact and relative importance of vocational evaluations, which might be seen as either rebuttals to the permanent disability rating schedule itself (at least they were under Ogilvie), or whether they are simply alternative determination of total permanent disability "according to the fact" pursuant to Labor Code §4662(b).

IV.

CAUSATION AND APPORTIONMENT

Prior to the adoption of Senate Bill 899, legal apportionment was based upon the existence of pre-injury disability (or at least a condition which, based upon a reasonable medical probability, would result in disability within a foreseeable period of time). That changed with SB 899 (new Labor Code §4663 and §4664). In relevant part, §4663 provides that apportionment to permanent disability shall be based on causation. Labor Code §4664 essentially provides that the employer is only liable for the percentage of permanent disability directly caused by the injury arising out of employment, that prior awards of permanent disability are conclusively presumed to exist at the time of a subsequent injury and that the accumulation of all permanent disability awards issued with respect to any one region of the body shall not exceed 100%. The body regions are hearing, vision, mental and behavioral disorders, spine, upper extremities (including the shoulders), lower extremities (including the hips) and a catch-all region including the head, face, cardiovascular system, respiratory system, and all other systems not otherwise listed.

The issues arising with respect to causation, however, are complex, with the primary issues relating to whether or not causation relates to injury itself, or disability.

Prior to Senate Bill 899, even apportionment with respect to multiple injuries was muddled as a result of Wilkinson v. WCAB, 19 Cal. 3d 491 (1977), the original intent of which, it appears, was to find that multiple injuries to the same body part sustained with the same employer becoming permanent and stationary at the same time would be rated together. This principle was expanded farther and farther to include multiple body parts, and at times even different employers. This all came to an end with Benson v. WCAB, 170, Cal App. 4th 1535 (2009), which held that Wilkinson was abrogated by the adoption of Senate Bill 899,

stating that the plain language of Labor Code §4663 specifically requires a physician to determine what percentage of disability was caused by each industrial injury.

Applicant's attorneys attempt to escape the effect of the Benson doctrine based on the argument that the Benson stated that where the injuries are "inextricably intertwined", then a Benson apportionment does not apply, and the injuries can be rated together. Except, however, that Benson did not say that. In fact, Benson never used the term "inextricably intertwined", and how that term found its way into workers' compensation law is somewhat unclear. What Benson actually said was:

> "We also agree that there may be limited circumstances, not present here, when the evaluating physician cannot parcel out with reasonable medical probability, the approximate percentages to which each distinct industrial injury causally contributed to the employee's overall permanent disability. In such limited circumstances, when the employer has failed to meet the burden of proof, a combined award of permanent disability may still be justified."

The Association suggests that virtually any attempt at apportionment between separate industrial injuries is based upon some degree of speculation, which doctors, if they are actually honest, will admit, and thus state that the injuries are "inextricably intertwined". This ignores Benson which states that a physician's inability to "parcel out" approximate percentages is expected to happen in only "limited circumstances". The point is that no medical opinion is "certain". "Medical probability" actually admits to a certain amount of speculation and/or guess work, and what the apportionment determination really calls for (like any medical opinion) is an educated judgment call.

Some further guidance is going to be necessary, it appears, since the doctrine of disability is being "inextricably intertwined" seems to becoming a part of the landscape. Espinosa v. Floser, Inc., Case Nos. ADJ924444 and ADJ7065158 (Panel Decision, May 9,

2016) glossed over Benson's language (stating a joint award of permanent disability may be warranted under "certain distinct circumstances", when Benson did not say that at all, using instead the term "limited circumstances") affirmed a finding that disability resulting to multiple body parts as a result of two separate injuries was "inextricably intertwined", after the examining doctor was browbeaten in his deposition to concede that apportionment was speculative. (He obviously had a reason for applying percentage apportionment at the time of his report.)

In any event, the doctrine of disability is being "inextricably intertwined" appears to be the applicant's holy grail in connection with Benson.

The concept of vocational apportionment versus medical apportionment was touched on somewhat in the prior section. To constitute substantial evidence, a vocational rehabilitation experts' opinion must consider non-industrial contributing factors to vocational non-feasibility. Floser Corporation v. WCAB, (Espinosa), 81 C.C.C. 812 (2016). Thus, the vocational rehabilitation consultants who do not consider the impact of pre-existing, non-industrial medical factors will be found to have expressed opinions not supported by substantial medical evidence. Thus, in Hamilton v. Hemborg Ford, 44 C.W.C.R. 222 (2016), applicant was found to be 100% totally disabled, although 5% of this disability was apportioned to non-industrial factors. The vocational expert submitted a report to the effect that, because of the total disability, applicant was unable to compete in the open labor market, and was thus totally disabled on a vocational basis. The report was found not to constitute substantial medical evidence because the vocational evaluator did not consider the impact the 5% non-industrial apportionment. Similar is Sutter Medical Foundation v. WCAB (Moulphrop), 79 C.C.C. 1570 (writ denied 2014), in which applicant received a permanent disability award of 72%, despite a vocational assessment finding a total loss of earning capacity under Labor Code §4662, as there was apportionment to applicant's non-industrial psychiatric condition.

An interesting case is Williams v. WCAB, 78 C.C.C. 811 (2013), which involved a rating of less than 100%. The AMA Guide rating was 16%, and the vocational expert's rating was 35% (which was apparently found credible). Eighty percent (80%) of applicant's disability was apportionable to the industrial injury, so the judge applied this percentage to the earning capacity loss, and came up with an overall rating of 25%. The WCAB apparently found this method to be acceptable.

It remains true, however, that to rebut the schedule of permanent disability rating, a showing is required that the employee is not amenable to rehabilitation due to industrial injury, and an opinion finding applicant unemployable based upon academic/intellectual limitations and/or histories of primarily unskilled work, is a finding based upon "impermissible factors" that cannot be considered in determining a diminished future earning capacity (or an ability to compete in the open labor market). Edwards v. WCAB, 81 C.C.C. 1035 (2016).

A case which truly has applicant's attorneys up in arms is City of Jackson v. WCAB (Rice), 82 C.C.C. 437 (2017), in connection with which there is a currently pending petition for hearing before the Supreme Court. The case involved a relatively short-term cumulative trauma (less than five years) to the neck, shoulder and hands of a 29-year-old police officer, and a Panel Qualified Medical Examiner found that applicant's condition was caused by a combination of work activities for the City of Jackson, prior work activities, applicant's personal activities, as well as a history of smoking. The QME reviewed several publications, and concluded from these studies that genomics (genetics) were a significant cause with respect to applicant's spinal disability, so he concluded that 49% of applicant's disability was attributable to applicant's personal history, including genetic issues. Although the WCAB granted reconsideration, the District Court of Appeals reversed, observing that there is no relevant distinction between apportionment of pre-existing congenital or pathological conditions in allowing apportionment to heredity or genetics. Applicants' attorneys take the

position that this type of apportionment is an unlawful, invidious discrimination based upon physical disability or genetic information.

Admittedly, an apportionment based upon genetics alone seems an awful lot like apportionment based solely upon "risk factors", and is thus suspect. Applicants' attorneys, of course, attempt to carry the banner too far, arguing that pre-existing pathological conditions (such as arthritis which, without question, has a disabling affect) should be excluded on this basis, but it appears it is possible to establish a line here. Genetics and degeneration are not the same thing. Blurring the line is not really helpful to anyone.

On the other hand, the case which has the Association salivating is a District Court of Appeal Decision which issued on June 22, 2017, Hikida v. WCAB. In this case, applicant had bilateral carpal tunnel syndrome, which was apportioned 90% industrial and 10% non-industrial. Surgery went terribly wrong, and applicant developed chronic regional pain syndrome from the surgery, which, by itself, was found to render applicant 100% permanently disabled. Applicant was found to be 100% permanently totally disabled on an industrial basis, without apportionment, and defendant, naturally disappointed, appealed.

This case turns on the difference between causation of injury (which is the carpal tunnel syndrome itself, together with its apportionment) and causation of disability (the disability condition which resulted from the surgery itself). The award was upheld because applicant's chronic regional pain syndrome alone was 100% disabling, and this condition was the direct result of the surgery (rather than the injury). The court explained that because medical treatment is not apportionable, neither are the disabilities which arise solely as the result of that medical treatment.

Quite frankly, we have seen cases like this before, dealing with the effects of medications (where an applicant becomes addicted or even develops severe medical

conditions as a result of medications being taken for the industrial injury) where such conditions themselves are not apportionable. We suppose the word here is that the effects of malpractice are not apportionable.

What applicants' attorneys are projecting from this case is a new look at apportionment with respect to joint replacement cases (knee replacements, hip replacements and the like). Normally, the conditions which precipitate such joint replacements are partially industrial, and partially non-industrial (usually, a lot of arthritis). However, the joint replacements generally have the effect of clearing out all of the arthritis, so the argument goes that there is no longer any basis for apportionment, since the residual disability is solely with respect to the effects of the surgery itself. In fact, there are AMA Guide impairments which are based solely upon a surgery which is performed, and it is argued that, where an impairment is based upon a surgery, it is based on medical treatment, which is non-apportionable.

We will have to see how this plays out, but we suspect that these will be the next hot topics with respect to apportionment.

Before leaving this section, there are several death cases which are worth noting. South Coast Framing v. WCAB (Clark), 60 Cal. 4th 909 (2015) is a California Supreme Court case in connection with which the worker died of an accidental overdose of medication, with the following drugs being detected: Elavil, Neurontin, Xanax, Ambien, and Vicodin. Applicant was receiving his prescriptions from two doctors, a workers' compensation doctor and his personal doctor (who was prescribing the Ambien for sleep problems, and Xanax because of an anxiety attack related to an apparently non-industrial surgery). The PQME initially concluded that only the drugs prescribed by applicant's personal physician (Ambien and Xanax) played a role in applicant's death. When pushed in his deposition, he conceded that Elavil might have played a minuscule role, "not zero",

possibly "1%", and the doctor's concession that the contribution of the Elavil was not at zero percent was enough to establish that it was a contributing factor to applicant's death. In death cases, the causation level is measured by whether or not something is a "contributing factor", and since the PQME conceded that the contribution of the Elavil was not at "zero percent", then that was enough.

This brings us to a couple of suicide cases. Rockefeller v. State of California, Case No. ADJ 8339009 (Panel Decision), May 30, 2017. Applicant, a correctional officer, appeared to be agitated when he arrived home and apparently had had some beers, and he shot himself. The QME noted the cover letter advising that the case was primarily a "stress case," and, although he did not actually diagnose a psychiatric injury, the QME discussed predominate causation attributing 20% to cumulative psychological stress on the job and 80% to non industrial factors. The WCAB noted that acts of suicide do not generally arise directly from events of employment and is generally considered to be a compensable consequence of an underlying industrial injury. In this case, industrial injury was alleged with respect to the decedent's psyche which contributed to his suicide.

Since this is the case, an industrial psychiatric injury had to be proved with the elements relating to whether actual events of employment caused psychiatric injury, and, if so, whether those events of employment were predominate to all causes. Only then can the examination proceed to whether or not there was a compensable industrial injury in the form of the suicide. As these elements have not been adequately addressed, the matter was remanded.

Xerox Corporation v. WCAB (Schulke), 82 C.C.C. 273 (writ denied, 2016) takes a different (and possibly conflicting) approach. In this case, applicant died as the result of a fatal heart attack which was linked to work related stress although the Agreed Medical

Examiner felt only 10% of the causation related to applicant's heart attack was related to this stress (The other factors relating to the heart attack were completely non-industrial.).

The defense missed the point in this case taking the position that since stress accounted for only 10% of the causation of the heart attack, it failed the burden of proof required under Labor Code §3208.3. That is not true. The real question was whether psychological stress was predominately caused by work (there is a suggestion in the case that it was, although the question was not really clearly addressed.). If it was, then it is a contributing factor with respect to the heart attack, and the death was industrial.

The Board seemed to miss this point as well, taking a position that when stress causes a physical injury such as a heart attack, Labor Code § 3208.3 is not applicable, which of course misses the point completely. This ignores causation in connection with the stress (which then contributes to the heart attack). The analysis with respect to causation of the stress itself was completely ignored. The end result here might not necessarily be incorrect, but the correct analysis seems to be completely missing. Quite frankly, it appears the commissioners were wrong; a psychological injury analysis is probably required here.

V.
MEDICAL TREATMENT

Despite attempts to go beyond the Court of Appeals, Stevens v. Workers' Compensation Appeals Board, 80 C.C.C. 1262 (2015) is final, and stands for the proposition that the Utilization Review and Independent Medical Review process, fashioned in Senate Bill 863 is constitutional. A second attempt to present the same arguments was rebuffed in Ramirez v. WCAB, 82 C.C.C. (DCA, 2017), where the court held that the plenary power of the legislature under Article 14, Section 4 of the California Constitution, precluded any constitutional challenge to the UR/IMR system based upon the Separation of Powers clause.

The court also noted that the process affords the injured workers sufficient opportunity to present evidence and be heard, so that the independent review process satisfies both state and federal principles of due process.

Stevens took an interesting twist, on its return to the WCAB from the Court of Appeal. The underlying independent medical review decision upheld a decertification of proposed housekeeping and personal care services on the ground that they were not forms of medical treatment pursuant to the 2009 Medical Treatment Utilization Schedule. In Stevens v. Outspoken Enterprise, ADJ1526353 (Panel Decision, May 19, 2017), the Board found the IMR determination was "adopted without authority" by the Administrative Director because a portion of the Medical Treatment Utilization Schedule providing that housekeeping and personal care services were not forms of medical treatment were contrary to longstanding workers' compensation law, which recognizes such services as forms of medical treatment that may be reasonably required to cure or relieve the effects of industrial injury. The matter was remanded with instructions that other sources needed to be considered in evaluating the recommendation (the suggestion was that the matter would be ordered to a new Independent Medical Review). This is consistent with Rodriguez v. Simi Valley Unified School District, 45 C.W.C.R. 19 (2017), which confirms that home health care is medical treatment, and the medical recommendation for a home health care evaluation was a medical treatment recommendation, which is subject to Utilization Review and IMR.

Returning to Ramirez. The decision also held that IMR's use of a improper standard of review does not invalidate the decision, as a determination with respect to what standards to use should be left to Independent Medical Review.

Applicant's attorneys have been postulating that, where a medical provider network was being used, traditional Utilization Review did not apply, but rather medical decisions were subject to the review process set forth in the MPN statutes, i.e., second and third

opinions within the MPN, followed by an Independent Medical Review by a physician appointed by the Administrative Director (which could involve an evaluation of the applicant). In Parrent v. SBC-Pacific Bell, Case Number ADJ339088 (Writ denied, 2016), the Panel rejected this argument, noting that the MPN-IMR process is activated by an injured worker, and that there was nothing in the statutory provisions creating the MPN system that showed a legislative intent to exempt MPN medical treatment recommendations from Utilization Review, noting also that every employer was mandated to implement a Utilization Review process that applied a uniform standard of review based upon the Medical Treatment Utilization Schedule. The Court of Appeal actually wrote a brief opinion in connection with its denial of review, primarily pointing out that the review system specifically set forth in the MPN statute is for injured workers, not employers, and that an employer's method of contesting medical treatment recommendations was through the normal Utilization Review process (Parrent v. Workers' Compensation Appeals Board, DCA Case Number D071162 January 5, 2017).

Applicant's attorneys have long complained that the Utilization Review process was stacked against applicants because carriers failed to provide utilization reviewers with sufficient information to make appropriate decisions. McKinney v. Enterprise Rent-A-Car of San Francisco, 2016 Cal Work Comp PD Lexus 495 (2016) provides the answer to this, holding that a defendant's failure to submit applicant's complete medical records to Utilization Review did not constitute a failure to comply with defendant's statutory obligations or indicate bad faith. Instead, it is the primary treating physician, and not the claims examiner, who is responsible for submitting an adequate medical record along with his request for authorization, for the purpose of substantiating the need for the recommended medical treatment.

The importance of Utilization Review from a defense standpoint really needs to be underscored, however. A ridiculous case appears to be Goodwill Industries v. Workers'

Compensation Appeals Board, 74 C.C.C. 867 (2009). This was a lien case, in which a surgical center was attempting to collect facility fees charged in connection with 78 epidural steroid injections administered based on a recommendation of the treating physician within a two-year period between 2001 and 2003. Despite an Agreed Medical Examiner's subsequent opinion that three or four of these injections were the maximum that should have been administered, the WCAB determined that the lien claimant was entitled to payment since the Agreed Medical Examiner's report was not received prior to the conclusion of this outrageous abuse of medical treatment. Granted, the services here were prior to the use of mandatory Utilization Review, but even so, perhaps the Board should have been somewhat more sophisticated in connection with evaluating reasonableness and necessity of treatment, Utilization Review would hopefully prevent a recurring situation like this.

A final word with respect to MPN access standards in connection with the case of Puente v. Napa Valley Unified School District, Case Number ADJ8911659 (Panel Decision, February 24, 2017). In connection with primary care physicians, MPN access standards require availability of at least three within a 15 mile/30 minute radius of applicant. In connection with specialists, there must be availability of three within a 30 mile/60 minute radius. One game, to escape the MPN, has been the attempt to select a specialist as a primary treating physician, then argue there were not a sufficient number of these specialists within the 15 mile/30 minute range. Some cases suggested that this was a legitimate tactic.

Puente suggests differently. This case involved selection of a pain management specialist, in connection with which there were three within the 30 mile/60 minute radius, but only two within the 15 mile/30 minute radius. The court suggested applicant was not necessarily entitled to a pain management specialist within the PTP radius, only that three physicians be located within that radius who had a specialty appropriate to provide ongoing primary care for the applicant's injury, and who were willing to serve as a primary treating physician. Thus, a pain management specialist was not necessarily required.

VI.

INVESTIGATION, DISCOVERY, AND EVIDENCE

Regulation 10109 generally creates a duty on the part of the employer (carrier) to investigate a claim of industrial injury, not only in connection with the original report of injury, but additional facts with respect to that injury as the case develops. A failure to investigate and provide required notices can toll the Statute of Limitations indefinitely, and can also lead to sanctions. The duty commences upon knowledge of a claim, and continues. If later information is uncovered which was not previously known, then the regulation creates a duty to investigate further. The investigation must be documented in the claims file, and the carrier must deal fairly and in good faith with workers. The fact that the worker has the burden of proof in connection with an industrial injury does not excuse the carrier's duty to investigate.

A cautionary case in this regard is Brenton v. Sterling General Construction, 2017 Cal. Wrk. Comp. P.D. LEXIS 80 (2017), in which the carrier was sanctioned $2,000.00 based on the finding that the carrier frivolously litigated the issue of compensable consequence injury to applicant's psyche, despite having no medical evidence to dispute psychiatric injury, and no reasonable basis to doubt medical reporting from two physicians that applicant had a compensable psychiatric injury. The Board's position is that if the employer receives unrebutted medical reports supporting an employee's claim, the employer must promptly seek rebuttal evidence or accept liability; simply delaying the provision of benefits is not acceptable.

In terms of discovery, there is a tension between defendant's need to know, and applicant's claims of privacy. This dates back to Allison v. WCAB, 64 C.C.C. 624 (DCA, 1999), holding that a Workers' Compensation applicant does not completely waive rights to

medical privacy, but that the scope of discovery depends on the nature of the injury being claimed by the applicant (and in this case, the attempt to explore applicant's hospitalization history over the 30-year period was found to be an invasion of applicant's privacy). A disturbing trend, however, appears to be applicant's attorney's suggestion that an applicant should be able to define the scope of medical discovery in terms of the injury being claimed. Lopez v. Penterman Farming Company, 2015 Cal. Wrk. Comp. P.D. LEXIS 598 (2015) affirmed an order limiting defendant's request for medical records, ruling applicant did not waive all medical privacy, and that defendant was limited to discovery of medical information relative to the of the injuries which applicant asserted. This puts the defendant at a disadvantage, when an applicant is permitted to designate which records specifically relate to the injury being claimed, (how often have we obtained medical records which were claimed not to be relevant to a particular injury, only to find that there was medical treatment with respect to the body parts at issue); it especially becomes critical with the allegations regarding compensable consequence injuries.

In Morales v. Alsin Electronics, 206 Cal. Wrk. Comp. P.D. LEXIS 28 (2006), applicant refused to answer questions with respect to whether she had a family doctor, whether she had ever been hospitalized, whether she had undergone surgery, or whether she ever received treatment in an emergency room. And although the judge found that applicant's refusal to answer these questions was unjustified, (which appeared to be legitimate enough, or perhaps a little too broad in terms of time), the matter was remanded to see if the questions could be narrowed down.

Sensitive categories for discovery relate to prior sexual conduct, as well as drug and alcohol use. Labor Code §3208.4 (cases involving sexual harassment, assault, or battery) declares that any party seeking discovery concerning the applicant's sexual conduct must establish specific facts showing good cause for that discovery on a noticed motion to the Appeals Board. See Aguilar v. Harris Ranch, 43 C.W.C.R. 177.

Psychiatric, drug and alcohol discovery is obviously going to relevant where psychiatric injuries are alleged. It is also suggested that this evidence may be relevant as well in connection with vocational claims, since these issues could well have an impact on applicant's ability to seek or keep work.

Code of Civil Procedure §2025.610 generally prohibits multiple depositions of an individual without a showing of good cause. The time of a deposition (direct examination) is also limited to seven hours in most cases, pursuant to Code of Civil Procedure §2025.290(a). Good cause generally relates to changed circumstances, which warrant further discovery. Nelson v. Renaissance Hollywood Hotel, 2011 Cal. Wrk. Comp. P.D. LEXIS 547 (2011). However, the stated desire to clean up a few matters, coupled with a twisting of the facts with respect to what occurred at the first deposition was considered bad faith, warranting an award of sanctions and attorneys' fees in Wellmann v. United Temporary Services, 2012 Cal. Wrk. Comp. P.D. LEXIS 163 (2012).

An issue which arises from time to time is with respect to the employer's right to be present at the deposition. As a practical matter, this can be problematic for the defense, since the presence of the employer can cause tensions during the deposition, with the result being that applicant may not be as free with respect to the disclosure of information as he/she might otherwise be in a more relaxed setting. However, if the employer wishes to attend (generally by way of an appropriate representative), we think that, pursuant to Code of Civil Procedure § 2025.420(b), the employer has an absolute right to be there and to be present during the entire deposition, notwithstanding Labor Code §3762(c), which prohibits the carrier/administrator from disclosing or causing to be disclosed to an employer any medical information other than a diagnosis, or that which is necessary for the employer to modify work. The employer is a party [as defined in Code of Civil Procedure § 2025.420(b)], and the exclusion of any party from a discovery proceeding would appear to be a denial of that party's rights to due process. See Moran v. Bradford Building, 57 C.C.C. 273 (1992).

County of San Bernardino v. Workers' Compensation Appeals Board (Foroughi) 79 C.C.C. 1200 (2014) at first glance appears to run counter to this contention, but probably does not. Applicant claimed psychological injury as a result of harassment and mistreatment by her supervisor. At her deposition, the supervisor showed up as the employer's designated representative and applicant flipped out. Applicant's doctor indicated that being forced to testify in the presence of the supervisor would cause a decompensation of applicant's condition, and the supervisor was barred from attending.

There are several problems and factors at work here. First, as noted at the start of this discussion, the environment created by putting the supervisor and the applicant in the same room together does not promote good discovery, and it certainly gives the Board the opportunity to question the employer's motives. The employer was not prohibited from designating a representative for attending, but simply advised that the particular representative chosen in this case (the supervisor) was inappropriate. Quite frankly, an appropriate employer representative, we think, would be someone in high management, and that should have been the choice here.

An applicant's deposition may be videotaped, as that is a procedure which is contemplated by the Code of Civil Procedure § 2025.33(c), as long as appropriate notice is given with respect to this, Reed v. 99 Cent Only Store, 2011 Cal. Wrk. Comp. P.D. LEXIS 136 (2011). Despite this, the Workers' Compensation Appeals Board has not really adequately addressed how to enforce the taking of an applicant's deposition. In Murray v. Intuit, 2009 Cal. Wrk. Comp. P.D. LEXIS 389 (2009), the WCAB rescinded orders suspending proceedings and barring payment of benefits because of an applicant's refusal to attend a deposition. However, the Board has the authority to enforce discovery, and it certainly does have authority to enforce its orders with respect to appearing at a deposition. Admittedly, the Labor Code has no specific provisions with respect to this, but the Code of Civil Procedure does.

With respect to deposition fees, we do note that, at this time, at least several of the Workers' Compensation Appeals Boards (Stockton and Oakland, for example) are authorizing Labor Code §5710 deposition fees up to $400.00 per hour for attorneys with ten or more years of experience, or a certified specialist. We also note that a deposition transcript review with the applicant subsequent to the deposition appears to be a permitted service, at least according to one judge (Jurnigan v. Walmart, ADJ 8653694), and we have seen a decision allowing a deposition review with the applicant of a prior transcript where a second deposition is being taken (although this would appear to fall within the province of preparation).

In terms of discovery, social media is pretty much fair game (at least that which is readily available); if privacy settings prevent online discovery, discovery motions may produce orders for authorizations, assuming good cause can be shown. Immigration status, however, is not fair game (Labor Code §1171.5: a person's immigration status is irrelevant to the issue of the liability). State Bar rules subject attorneys to discipline if they report immigration status (or threaten to report immigration status) in connection with the litigation for purpose of obtaining an advantage.

A couple of final notes in connection with trial. Although a party may use evidence designated by another party without having designated that evidence himself (Bank of America v. WCAB (Chand) 79 C.C.C. 1075 (2014)) if you really want applicant's testimony, then a defendant needs to make arrangements to enforce his appearance at trial (by way of notice to appear or subpoena), rather than counting on him to just show up. Pamplen v. State of California, 2016 Cal. Wrk. Comp. P.D. LEXIS 275 (2016). If he does not show up, the judge has the discretion to proceed to Trial in his absence, submitting the matter on the record.

In connection with Panel Qualified Medical Examiners, an important case is Maxham v. California Department of Corrections, 82 C.C.C. 136 (En Banc, 2017). The case involves the difference between "information" and "communication", although it involved an agreed medical examiner, rather than a Panel Qualified Medical Examiner. The court noted that Labor Code §4062.3 defines "information" as including treating physician records, and medical and non-medical records relevant to the determination of medical issues. It noted that a communication (i.e. a letter to the doctor) can constitute "information" if it contains references or encloses those things identified directly as information.

In this case, the party transmitted an advocacy letter with a number of record references and argument, together with documentary material, directly to an agreed medical examiner over the objection of the other party. The workers' compensation judge initially determined that the letters were nothing more than communication; the Workers' Compensation Appeals Board undertook review with the observation that previous rulings with respect to Labor Code §4062.3 may have created confusion. It clarified that as long as the letter was served on opposing counsel, it was not an ex parte communication, but that the advocacy letter itself might contain information of a nature which requires consent of the opposing party to submit to the evaluator (or else a dispute is created which should be resolved by the judge). The Board made no specific findings with respect to the documents in this case, but simply remanded to the matter back to the judge for further proceedings.

In terms of what can be sent to the Panel Qualified Medical Examiner, it does appear that the Workers' Compensation Appeals Board is inclined to allow a submission of reports obtained by applicants at their own expense, pursuant to Labor Code §4605 (there does not seem to be a corresponding section for the employer). Davis v. WCAB, 82 C.C.C. 187 (2017). It is also noted that a failure to timely submit a supplemental medical report (assuming everything else before it has been timely) is not necessarily grounds to disqualify a Panel Qualified Medical Examiner. Corrado v. Aquafine Corporation, Case Nos. ADJ9150447 and 9150446 (Panel Decision, June 24, 2016).

VII.

PSYCHIATRIC INJURIES

Issues continue to arise with respect to Labor Code §4660.1(c). No increased impairment is allowed for consequential psychiatric injuries unless the applicant is the victim of a violent act, or a sudden and extraordinary event of employment pursuant to Labor Code §3208.3(d).

Illustrative is Raiszadeh v. County of Riverside, Case No. ADJ10180048 (Panel decision, May 8, 2017) where applicant, a social worker, was struck in the back of a head in connection with an assault by a woman in a home she was visiting. The issue was whether this constituted a sudden and extraordinary event within the meaning of Labor Code §3208.3(d) and the Board found that applicant, a social worker, was not engaged in an occupation where violence was expected, and that she would not have to expected to have been physically assaulted by a member of the public. For this reason, the psychiatric injury was found to be compensable.

In Madsen v. Michael J. Cavaletto Ranches, 45 C.W.C.R. 65 (2017), an applicant was driving a truck when, in attempting to avoid a collision, he rolled over, becoming pinned within the cab of the truck. Ordinarily, one would think that motor vehicle accidents would be an expected part of the occupation of a truck driver, but here applicant was a claustrophobic, was trapped within the cab for a prolonged period of time with leaking gasoline, and a fear that he would be burned to death. This was felt to be a direct psychiatric injury (as opposed to a compensable one pursuant to Labor Code §4660.1), although the Board also felt that the circumstances of this accident were a "violent act" within the meaning of that statute.

A little more difficult to understand is Torres v. Greenbrae Management, Case No. ADJ9355637 (Panel Decision, May 19, 2007), which held, in part, that applicant's fall from a tree while trimming it was a violent act within the meaning of Labor Code §4660.1. The issue is really what is unexpected by an injured employee given the nature of his employment, and, if an applicant is a tree trimmer, then falling out of a tree, while certainly traumatic, should not be unexpected.

The problem with this case is that this part of the ruling was probably not necessary, since the Board found, initially, that §4660.1 did not apply, and that applicant suffered a direct psychiatric injury as a result of the fall (was thus not a compensable psychiatric injury under 4660.1). The envelope definitely seems to be pushed, however, noting Larsen v. Securitas Security Services, Case No. ADJ9034489 (Panel Decision, May 17, 2016), where a security guard walking through a parking lot was hit by a car. This would appear to be a foreseeable risk of performing work within a parking lot and, under the circumstances, should not be subject to one of the exceptions.

VIII.

OTHER ISSUES CONSIDERED

The Medical Injury Compensation Reform Act of 1975 (MICRA) generally bars subrogation in malpractice claims. MICRA, however, does not preclude the application of credit (at least insofar as malpractice has resulted in an additional disability, or a requirement for payment of additional benefits). In Edwards v. City of Los Angeles, Case No. ADJ10021120 and ADJ8949346 (Panel Decision, April 14, 2017). applicant died as a result of an industrial cardiovascular accident, in connection with which there was a malpractice settlement by his dependents with Kaiser. Citing Bernstein v. WCAB, 61 C.C.C. 484 (1996), the Board found that, in the absence of proof that the malpractice settlement was reduced to

reflect workers' compensation benefits to which the dependents would be entitled, defendant's credit rights would not be limited, and these credit rights would apply to death benefits.

In Quintanilla v. Sun Health Care Group, Case No. ADJ8710457 (Panel Decision, March 14, 2017), the Commissioners held that an applicant is still entitled to attempt to show employer negligence in connection with the initial industrial injury, for the purpose of reducing the credit from a malpractice settlement or recovery.

There is a suggestion that, if an employer refuses to offer a return to work to an applicant deemed capable of returning to work following an industrial injury, that there may well be a FEHA violation, which could be actionable. This is an issue which employers should keep in mind.

A somewhat strange jurisdictional case was County of Riverside v. Worker's Compensation Appeals Board, 82 C.C.C. 301 (2017), where applicant worked as a Sheriff for the County through October, 2010, then worked for an Indian Reservation Police Department through July 2014. He was not advised that his medical conditions were industrially related until 2013, and he filed an Application within a year of that advice. The county contended applicant's claim was barred by the statue of limitations, or, alternatively, it was barred by Labor Code §5500.5, as the County was not within the last year of injurious exposure. It lost on both grounds. It was noted applicant did file his application within a year of knowledge, and that the Workers' Compensation Appeals Board did not have jurisdiction over the Indian tribe, so the period of injurious exposure backed up to the last employer with insurance, which would have been the County.

IX.

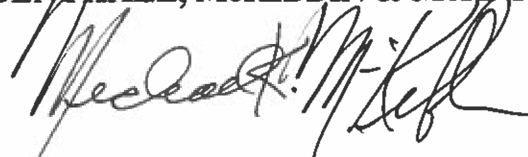
CONCLUSION

We hope you found the foregoing work to be of interest. The pendulum seems to be swinging back in applicant's favor with respect to issues of apportionment and causation. If what we heard at the convention is any indication, we will probably be seeing more vocational evaluations, as applicant's attorneys see these evaluations as a method of avoiding medical apportionment.

If you have any questions or wish to discuss the issues outlined in this presentation further, we would be happy to do so, either by telephone, by way of continuing education seminars. We hope this has been of service to you.

Very truly yours,

BENTHALE, McKIBBIN & McKNIGHT



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