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THE DEFENSE PERSPECTIVE AND OBSERVATIONS OF THE CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION 2015 SUMMER CONVENTION

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2015 SUMMER CONVENTION OF THE
CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION
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I.

INTRODUCTION

TO OUR CLIENTS:

The Semi-Annual Summer Convention of the California Applicant's Attorney's Association held June 25, 2015 through June 28, 2015 was actually a little bit of a surprise. Almost in the words of that forgotten newscaster from Saturday Night Live years ago, who said something to the effect, "Today, nothing happened", there really was not very much new.

In his introduction to the review of recent cases over the last six months, Panel Moderator Joseph Capurro frankly stated that "over the past six months there has been little in the way of published decisions." The one major decision presently being awaited (Stevens) on the constitutionality of IMR is still bottled up in the Court of Appeal, with no estimate as to when something might be expected.

Thus, many of the recent decisions noted in this report are panel decisions which really have no binding precedent on anyone (including other panels), although many judges would probably be inclined to look to these decisions for guidance until something more precedential comes along.

There did not really seem too much of a single focus on anything during this convention although old standards relating to the piling on of ancillary impairments (including reiteration of suggested methods to escape the restrictions on compensable consequences imposed by Labor Code §4660.1) did receive attention. So, that is where we will start.

II.
COMPENSABLE CONSEQUENCES

Still sticking in CAAA's craw is Labor Code §4661.(c), pretty much enacted in response to the automatic inclusion by many applicant's' practitioners of allegations of psychiatric, sleep and sex consequences with respect to every injury filed, no matter how minor (and the enthusiastic willingness of many of applicants' doctors to load up the billings with multiple referrals in connection with these claims). In essence, Labor Code §4660.1(c) provides that there should be no increases in impairment ratings for sleep dysfunction, sexual dysfunction, or psychiatric disorder, or any combination thereof, arising out of a compensable physical injury. Treatment for these disorders is permitted, however, assuming they exist and treatment is necessary, and there are two exceptions to the bar against consequential psychiatric impairments: (1) being a victim of, or being directly exposed to, a violent act within the meaning of Labor Code §3208.3(b)(1) (which reduces the causation factor to "substantial cause" as opposed to "predominant" for this type of psychiatric injury, and, to a certain extent, this is more of a direct psychiatric injury rather than a consequential one) or (2) where the consequential psychiatric impairment is the result of a "catastrophic injury".

Just in passing, there seems to be some acceptance at this point in that the legislature is entitled to make distinctions as between various types of injuries in terms of their compensability. (After all, Labor Code §3208.3 has being doing that with respect to psychiatric injuries for years). Reference is made to *Davis v. City of Sacramento*, 138 Cal. App. 3d 356 (1982) where, in determining the amount of a police officer's pension, the police officer complained that psychiatric disability was treated differently than other injury for the purpose of calculating his pension amount, and alleged this amounted to impermissible discrimination. The court suggested that the legislature was concerned with

the fact that mental illness was more difficult to diagnose, and administering psychiatric claims in the same manner as a physical injury claim would produce a greater economic burden. Basically, the idea is that distinguishing between various types of diseases is an economic and social welfare issue which is subject to the "rational basis test", and as long as there is a rational basis for the determination (as the court felt there was here), the distinction is constitutional.

Thus, the argument made by the panelists to the effect that a "minor head injury" should allow the inclusion of a psychiatric claim as a direct result of the injury appears to be directly contradicted by the legislature's determination that a "severe head injury" is the benchmark. Not giving up, however, the panelists suggest the "minor head injury" scenario might well bring the case within the ambit of Chapter 13 of the AMA Guides, particularly those sections relating to consciousness disorders and cognitive impairment (although there is some suggestion that mental or emotional impairments can actually be evaluated under Table 13-8 of the AMA Guides, relating to emotional or behavioral impairments, this would appear to be just a blatant method of circumventing the direction that GAF be used for evaluating psychiatric injuries).

An alternative approach is the "catastrophic injury" and the idea being proposed is that an injury may be classified as "catastrophic" if the consequences of that injury are catastrophic. However, even in evaluating the examples given, this seems to be nothing more than circular reasoning (an individual has an injury, becomes depressed because of the injury, gives up on life, loses his home, family, etc.; although these consequences are certainly catastrophic, they say nothing about the nature of the actual injury itself). In County of Contra Costa v. WCAB (Guthery), 70 C.C.C. §1496 (2005), an applicant sustained a physical injury, with resulting "psycho-social" difficulty stemming from the resulting unemployment/financial difficulties which resulted from that injury, and the court specifically held that this was a compensable,

consequential psychiatric injury. In other words, consequences are just that: consequences; they may be minor, or they may be major, but they are still consequences.

We think that in referencing the term "catastrophic injury", the legislature was looking more at the event itself which caused the injury, rather than its later effects down the road (although granted, such events might eventually play a role). We think, however, that what the legislature considers catastrophic is suggested by the examples set forth in §4660.1(c)(2)(B): "Loss of limb, paralysis, severe burn, or severe head injury." Unless a physical injury is this significant, then we think a good argument can be made that it is not "catastrophic".

That is not to say that subsequent events in connection with an applicant's attempted recovery from a specific, physical injury might not make the injury itself "catastrophic". For example, a person with an otherwise minor physical injury, but with an underlying, serious medical condition which severely complicates the recovery process might well be said to have a catastrophic injury. To a certain extent, applicant's attorneys are probably closest to the mark in arguing that medication consequences can make an injury "catastrophic". The AMA Guides specifically state in §2.5(g) that "pharmaceuticals themselves may lead to impairments (and) in such an instance, the physician should use the appropriate parts of the Guides to evaluate impairment related to pharmaceutical effects." Chapter 14 of the Guides specifically states that medication "side effects should be considered and evaluated in the overall severity of the individual's impairment and ability to function (and) as explained in Chapter 2, the evaluator may need to provide an impairment estimate for the drug's side effects." At this point, Chapter 13 of the Guides may actually become relevant, the suggestion by the panelists being that Tables 13-5 and 13-6 (dementia criteria) be used.

The less likely in beating the Labor Code §4660.1 restriction is the suggestion that the practitioner file two claims, a specific injury claim in connection with the actual injury, concurrently with a cumulative trauma for the psychiatric, sleep, and sex dysfunctions. Of course, that cumulative trauma has to be based upon something (causation), and just because an applicant pleads it does not make it so.

Since the topic of this chapter is bolstering disability awards, included here is the ongoing argument that the Combined Values Chart unfairly minimizes the effect of overall disability. The AMA Guides (page 10) concedes that there is no scientific formula established indicating the best way to combine multiple impairments, noting that combinations of certain disabilities (i.e., blindness in both eyes, or inability to use both hands) certainly decreases overall functioning more than suggested by simply adding the impairments, although it notes that a less than additive approach is certainly appropriate with respect to considering the effects of other multiple impairments. As a practical matter, although the Combined Values Chart is the presumptively correct method of considering the effect of multiple impairments, it is rebuttable, and §2.5(g) of the Guides suggests a physician may use professional judgment based upon severity of effect.

We will include here a final word about new and further disability (Labor Code §5410; within five years after date of injury a worker can institute proceedings upon the ground that the original injury has caused new and further disability). "New and further disability" is essentially defined as disability in addition to that for which the employer previously provided benefits. Standard Rectifier Corporation v. WCAB, 65 Cal.2d 287 (1966). We all pretty much understand these principles, but it should be noted that, in the case of a minor, the five years actually does not begin to run until after the minor reaches the age of majority. Royal Indemnity Company v. I.A.C., 85 Cal.App.2d 373 (1948). Furthermore, while a petition to reopen may preserve the jurisdiction of the Workers' Compensation Appeals

Board to make further decisions with respect to changes in permanent disability, or perhaps claims with respect to additional body parts, it does not necessarily preserve Board's jurisdiction with respect to the award of benefits, the need for which specifically arise after the expiration of five years. Thus, where a need of further temporary disability arose after the passage of five years, the WCAB lacked jurisdiction to award it, despite the fact that a timely petition to reopen had been filed. Fekkers v. WCAB, 67 C.C.C. 92 (2001).

III.

PENALTIES AND SANCTIONS

Penalties seem to have become a much less important subject since the amendment of Labor Code § 5814 by SB 899, which essentially limited penalties to the amounts actually delayed (as opposed to the entire species), and limited the overall penalty to $10,000.00 (generally not seen except where there is delay in paying an entire settlement). As the Panel has noted, unless the delay is post award (in which case the attorneys' fee provisions of Labor Code § 5814.5 come into play), economically, most penalties are simply not worth pursuing.

A new approach which is being suggested, however, is to pursue delays as being bad faith actions warranting sanctions under Labor Code § 5813 (the Board is empowered to order a party to pay reasonable expenses, including attorneys' fees and costs, incurred as the result of bad faith actions or tactics). Section 5813 is somewhat explained by Regulation 10561, which gives various examples of what is considered bad faith, which includes failing to comply with rules and regulations, and regulations of the Administrative Director. The gold mine which is apparently being observed primarily relates to the Administrative Director's regulations relating to Utilization Review and independent medical review. Specifically, Regulation 9792.12 contains a laundry list of actions which subject a Claims Administrator to administrative penalties, including a number specifically related to the independent medical review process (failure to timely serve documents, and failure to serve all documents, etc.). The idea is to claim that failure to comply with these requirements is bad faith, and while the sanctions are generally payable to the Administrative Director's office, Section 5813 provides that an applicant's attorney could be awarded attorney's fees for pursuing them.

We note Judge Anne Horelly also remarked that sanction and penalty awards are supposed to be reported by Workers' Compensation Judges to the Administrative Director's office, and these reports potentially could trigger a penalty audit, and, although no one has heard of such penalty being imposed, there is a potential of the so-called "big foot" penalties (Labor Code § 5814.6, $400,000.00, and Regulation 9792.12(b)(3), administrative penalties from $100,000.00 to $400,000.00).

The panelists also noted *Hernandez v. State Compensation Insurance Fund,* 43 C.W.C.R 11 (2015), a Panel decision which stands for the proposition that applicants' attorneys are entitled to attorneys' fees for the time spent attempting to collect attorneys' fees in connection with a penalty claim.

We had some concern with the effect of *Torres v. AJC Sandblasting,* 77 C.C.C. 1113 (En Banc, 2012), which dealt with the sanctioning of a lien claimant for attempting to proceed to trial with nothing more than a billing (basically, the lien claimant had no evidence to support his position). There were suggestions from applicant's attorneys that the rationale of this case could be applied to defendants who proceeded to trial with what applicants' attorneys and/or judges would perceive as being a lack of evidence. Our concern is alleviated somewhat by *Fernandez v. Oakdale Memorial Park,* Case No. ADJ 9105145 (March 5, 2015), a Panel decision involving this exact same point. In this case, defendant was sanctioned for proceeding to trial without supporting evidence, but the sanction award was vacated by a Panel (two of the three anyway; one felt the sanction was warranted), on the basis that the employee, irrespective of what the employer does or does not do, still carries the burden of proof.

IV.

UTILIZATION REVIEW AND INDEPENDENT MEDICAL REVIEW ISSUES

As noted in the introduction, the most significant independent medical review issue pending before the courts right now relates to the claim that the independent medical review process is unconstitutional as it denies the applicant's due process by virtue of hiding the identity of the physician who is making the decision (the *Stephens* case). This case is presently pending on a Petition for Writ of Review before the Court of Appeals, and it would appear that a second panel decision, *McFarland v. The Permanent Medical Group*, 2015 Cal. Work. Comp. P.B. Lexis 23(2015) may be on its way as well (the case originally went up on a Dubon I issue based on a contention that Utilization Review had insufficient medical records to make the decision, although this ground was eliminated by Dubon II), following which the applicant took the approach that IMR was unconstitutional (and the Board held that it had no jurisdiction to review that issue).

Applicant's attorneys are somewhat encouraged by an unrelated case, *Ogden Entertainment Services, v. WCAB*, 80 C.C.C. 1 (2015), in which an award was vacated based upon the trial judge's position that the medical record established that applicant was 100%, totally disabled, and the defendant thus had no reason to cross examine applicant (applicant was uncooperative and refused to allow himself to be cross examined). The Court of Appeals stated that the refusal to allow defendant to cross examine the applicant was a denial of defendant's due process, noting that for at least two centuries the Anglo American evidentiary system has preserved the right of a party to test the credibility of a witness by cross examination.

That, of course, is the point being made in *Stevens, i.e.,* and the applicant's due process rights in connection with the provision of medical treatment are being violated by reason of medical decisions regarding their care being made by an anonymous individual who is not subject to cross examination.

Independent medical review is being attacked on another ground, and that is relating to the timeliness of utilization review decisions. So far, the leading case on the subject is *Aredondo v. Tri-Modal Distribution* (ADJ2440992) (May 12, 2015), a panel decision which held that, despite the lack of compliance with the timelines for submitting an independent medical review decision (30 days from submission of required documents), timeliness was not one of the appeal grounds which the WCAB had jurisdiction to consider in connection with the IMR decision, and, since there was nothing in the statutes authorizing the WCAB to determine medical necessity in the face of an otherwise valid IMR, lack of timeliness did not affect the validity of the IMR decision. The Board held that the timelines for IMR were "directory" rather than "mandatory", and the Board held that even if the IMR decision was felt to be invalid, the only remedy was to remand the matter back to the Administrative Director for another IMR decision (referencing Labor Code §§ 4610.6(h) and (i)).
Potentially, a petition for writ or review is going to be filed with respect to this case. We understand from the Commissioner's Panel that there are now two even more recent Panel decisions (one of which is Saunder), case number ADJ8107354) which suggest that an untimely IMR has the same effect as an untimely Utilization Review: the decision is invalid, and the WCAB may step in. CAAA takes the position that, if Aradondo stands, the essential result is that there is no remedy for a lack of timeliness with respect to Independent Medical Review, and there is no recourse to force Independent Medical Review to comply with the timelines. Admittedly, this is a serious problem, although, in light of the legislature's specific direction that the WCAB is not to become involved in questions of medical necessity

where there is an otherwise valid underlying Utilization Review, the question of an appropriate remedy is a very real issue.

V.
MPN ISSUES

There is still some gamesmanship on behalf of applicants and their attorneys in connection with compliance with MPN requirements. We start with Ramirez v. Nino Farms Labor, Case #ADJ9533697 (May 12, 2015), a case in which an applicant claimed entitlement to treat outside of defendant's MPN on the ground that the MPN list provided to applicant by the defendant included the names of some physicians who were not available to serve as primary treating physicians. The Trial Judge felt applicant could treat outside the MPN, but also noted that applicant's attorney had engaged in "litigation tactics" by apparently searching out and designating physicians who were not willing to serve in the capacity of primary treating physician, and used this as a basis for claiming that defendants conduct in including such physicians on its list constituted a neglect or refusal to provide reasonable medical treatment.

The WCAB Panel did not agree applicant could escape the MPN, and perhaps the gamesmanship engaged in by applicant's attorney had something to do with this.

A more disturbing case is Lescallett v. Walmart, Case #ADJ7422993 (April 6, 2015), in which applicant engaged in similar gamesmanship by attempting to designate a pain management specialist as his primary treating physician. The applicant claimed he was entitled to treat outside of the MPN because there was no pain management physician within 15 miles of his residence, although Walmart contended that, because applicant was designating a specialist (a pain management specialist), the criteria was actually that the physician be within 30 miles or 60 minutes of applicant's residence or workplace.

The WCAB Panel engaged in some tortured reasoning to hold that, since "specialist" was not defined, as long as the employee's selection of a physician was based upon the physician's speciality or recognized expertise in treating the particular injury, the pain management specialist was not really a "specialist", and the applicant was entitled to treat outside of the MPN. This decision, of course, renders the access standards specifically relating to specialists to be somewhat meaningless (in essence, the Panel's decision was that the "specialist" applied only to secondary physicians, rather than primary treating physicians).

In Everett v. Santa Clara Valley Transportation Authority, Case #ADJ2941731 (March 12, 2015), the holding was essentially that the requirement (relating to applicant's selection of a free choice physician) that such a physician be located within a reasonable geographic area of applicant's residence does not apply to applicant's selection of a MPN physician (Labor Code §4600(c) specifically states that this requirement applies unless the employee is subject to an MPN). We are not sure why an employee would select an MPN physician who is ridiculously far away and, although the case was not really clear with respect to this, we have to wonder if this dispute actually arose over transportation expenses.

Finally, we note Pasquel v. The Boeing Company, 2015 Cal. Wrk. Comp. P.D. Lexis 55 (2015), a case which, quite frankly, reflects somewhat badly on the defense. In this case (a lien proceeding), defendant refused to pay the bill of a MPN physician because he treated an applicant at an address which was different than the address listed for him on the MPN listing. There was no specific restriction in the MPN agreement which prohibited the physician from treating at addresses other than those listed on the MPN listing (although the doctor did have some contractural restrictions listed in connection with his contract agreement with U.S. Healthworks, which was the address of the MPN listing). The Panel agreed with the proposition that the Workers' Compensation Appeals Board should not involve itself in contract disputes between the MPN and its medical providers, except when

the behavior of the medical provider affects whether the treatment within the MPN satisfies the employer's obligation to provide medical care.

Quite frankly, unless there is a good reason for objecting to the physician's treatment of the applicant at a different address, we really cannot understand why some accommodation between the defendant and its MPN physician could not be reached here. This type of case tends to fuel applicant's attorney's arguments that defendants are willing to grasp at the most flimsy of reasons to avoid fulfilling medical care obligations (and we know that is not the case, but many applicant's attorneys believe it anyway).

VI.

MEDICAL TREATMENT ISSUES

Home Healthcare has received recent attention through the recent En banc decision of Hernandez v. Geneva Staffing, 79CCC682 (En banc, 2014), which essentially interpreted Labor Code §4600(h). This section provides that Home Healthcare Services shall be provided as medical treatment "only if reasonably required to cure or relieve" from the effects of the injury, and "prescribed by a physician and surgeon licensed pursuant to Chapter 5" (M.D. or D.O.). The significance of the prescription is that an employer has no liability for the cost of home healthcare provided more than 14 days prior to the employer's receipt of the prescription, but Hernandez suggested that the prescription could take many forms, and could be written or oral. The Board is likely to be somewhat liberal in considering exactly what a prescription is, nothing that there is a strong public policy favoring home healthcare services over institutionalization. Johns v. City of Los Angeles, 2014 Cal. Wrk. Comp. P.D. Lexis 718 (2014).

Adamson v. Cendant Corporation, Case #ADJ2621517 (February 18, 2015) is a Panel decision arising out of defendant's contention that a prescription for home healthcare services must be by a primary treating physician, and must be submitted to Utilization Review. In this case, the defendant had previously authorized home healthcare, and the Agreed Medical Evaluator subsequently rendered an opinion that applicant would benefit from home healthcare. The Primary Treating Physician subsequently requested authorization for home healthcare, which was decertified by Utilization Review.

In holding that defendant was obligated to provide home healthcare, the Panel invoked Patterson (to be discussed below), and also noted that there was nothing in the Statute which required that a prescription be by a primary treating physician, holding that any oral or written communication which meets the minimum requirements is sufficient to meet the condition in §4600(h) that Home Healthcare Services be prescribed. Thus, the Agreed Medical Examiner's opinion qualified. In Ferrona v. Warner Bros., Case #ADJ2263476 (April 10, 2015) (Petition for Writ or Review has been filed with respect to this case), it was held that the purpose of the prescription was to determine the date that an employer first became liable for Home Healthcare Services, not for the purposes of determining what is reasonable and necessary treatment (and, again, Patterson has application here).

Essentially, the prescription puts the employer on notice. Banuelos v. Nupla Corporation, 2014 Cal. Wrk. Comp. P.D. Lexis 485 (2014) held that the employer can receive an oral prescription for home healthcare at a doctor's deposition, and Adams v. Little Company of Mary Hospital, 2014 Cal. Wrk. Comp. P.D. Lexis 421 (2014), in connection with such an oral prescription, held that the defendant probably had a duty to investigate the potential need for home healthcare even if a medical professional not otherwise qualified to give the prescription suggested such a need.

That is not to say that Utilization Review does not play a role. It certainly does, at least in a situation where certain aspects of medical treatment (such as home healthcare) are prescribed for the first time. The mistake defendants make, we think, is taking the position that an iron clad requirement is that an RFA is required. It is not. Regulation 9792.12(a)(12), (13), and (14) all provide for rather stiff administrative penalties based upon the claims administrator's "failure to respond to a complete DWC form RFA or other Request for Authorization" (emphasis added). As Commission Chair Person Caplane remarked a convention or two ago, the lack of a formal RFA may cause relaxation of the Utilization

Review timeline (based upon the assumption that a non RFA Request for Authorization might not immediately be recognized for what it is), but at some point the claims administrator is going to be expected to act upon an authorization request, no matter what form it takes (as noted in the Adams , the duty to investigate the need for medical care is created).

And this brings us to Patterson v. The Oak Farm, 79 C.C.C. 910 (2014). While it is true that home healthcare (like any other medical treatment) is a proper subject of Utilization Review and Independent Medical Review, the Patterson line of cases holds, essentially, that an ongoing course of medical treatment cannot be unilaterally terminated by a defendant in the absence of a showing of a change of circumstances (and it is defendant's obligation to establish that such a change has taken place). Adamson v. Scendant Corporation, supra quoted Patterson for the proposition that unilaterally terminating medical treatment that was previously authorized as reasonably required to cure or relieve is contrary to Labor Code §4600(a), and Ferrona v. Warner Bros., supra, held that the contention that Labor Code §4600(a) requires an injured worker to obtain a renewed or updated prescription in order to continue ongoing home healthcare is without merit. Commissioner Chairperson Caplane commented that Utilization Review and Independent Medical Review were never intended to cut off ongoing medical care. This may present a special problem in so far as prescription medications are concerned, and we understand that there is a fairly recent case which is likely to be decided by the WCAB regarding this particular issue.

Just in passing, in terms of the timelines for Utilization Review, if a physician marks on the RFA that applicant is faced with an imminent serious threat to his health, that statement alone invokes the 72 hour rule for Utilization Review (in other words, no second guessing the physician). See Rodriguez v. California Insurance Guarantee Association, 43 C.W.C.R. 13 (2015). It also must be remembered that the timelines include communication of the

Utilization Review decision to the primary treating physician (Cordova v. SCIF, 43 C.W.C.R. 12 (2015), and by analogy, we would assume that this includes communication of the Utilization Review decision to applicant's attorney as well.

VII.
GENERAL PROCEDURAL ISSUES

Not too long ago, our firm assumed representation of a case and, in reviewing the proceedings which had gone on before we got the case, we noted applicant's refusal to cooperate in connection with his appearance at a noticed deposition, which resulted in the filing of a Petition to Compel applicant's appearance. We were dumbfounded by the Order Denying the petition, the judge's position being that since WCJ had no power to enforce the Order, it was meaningless, and he would not engage in a meaningless act. Quite frankly, that is an abdication of responsibility, and it is just plain wrong.

This is more or less just a simmering beef, but, while not as extreme as the Order referenced above, we do see similar expressions by many judges, particularly in connection with attempts to enforce orders relating to an applicant's appearance at a deposition (we get the Order Compelling, and applicant does not appear, and the judge then takes the position that he does not have power to do anything about it). That is wrong, too.

This diversion takes place in the context of the panel discussion with respect to privilege (among other things). Normally, in workers' compensation, there are three types of privileges which are commonly encountered: Attorney-client; work product; and privacy. Attorney-client is relatively well understood, and we do not see much litigation with respect to it. Work product and privacy receive the most attention. Privacy is likely to be the most significant subject of future litigation, given the increasing prevalence of social media, and the ability of Defendants to use this resource to investigate the background of applicants. The general consensus is that subpoenas do not work with social media entities, and that a social media entity is going to be unresponsive to any inquiry which does not involve the express consent of the user. A Workers' Compensation Appeals Board order may work, but we think the defense can forget about social media fishing expeditions, as we anticipate the

Board (assuming it is inclined to grant such an order) will narrowly define the scope of what is needed (and the enforcement of such an order against the nonparty is problematic, and will likely require obtaining a Superior Court enforcement order).

Perhaps the most prominent workers' compensation discovery case is Hardesty v. McCord & Holdren, 41 C.C.C. §111 (1976). In essence, Hardesty involved an applicant's attempt to obtain all of the defendant's investigative reports. The case can probably be referenced as standing for the proposition that mere witness statements, while nominally protected by the work product privilege, in a workers' compensation context are produceable (stripped to its basics, an applicant should not be put to the cost of hiring an investigator to interview witnesses, or taking their depositions, in a system where applicant's ability to obtain compensation should be expeditious and inexpensive). Investigative reports were a different matter, as these are statements of the investigator to the attorney who hired him, and were considered to be an integral part of the work product privilege.

There is language in Hardesty, however, which apparently convinces some workers' compensation judges that they have no authority to enforce discovery orders against applicants. This was Hardesty's discussion of the Discovery Act as embodied in the California Code of Civil Procedure, and Hardesty's observation that, "the procedural provisions of the Code of Civil Procedure relating to discovery are not applicable in workers' compensation proceedings". Despite this observation, however, Hardesty also noted that the Workers' Compensation Appeals Board must still "give force to the declaration of public policy implicit in those provisions and in the decisional law interpreting them that liberal pretrial discovery is desirable and beneficial for the purpose of ascertaining the truth, checking and preventing perjury, detecting and exposing false, fraudulent, and sham claims and defenses, and making available in a simple, convenient and inexpensive way facts which otherwise could not be proved except with great difficulty . . ."

Thus, while the Code of Civil Procedure sections relating to discovery certainly are not mandatory (and, primarily, we think the reference was actually with respect to several of the modes of discovery, such as interrogatories, which are allowed by these provisions), the principles with respect to the allowance of discovery certainly do apply.

This brings us to Allison v. Workers' Compensation Appeals Board, 64 C.C.C. §624 (1999), a Court of Appeal case standing for the proposition that, just because an applicant files an industrial accident claim, an applicant does not give up every right of privacy, and discovery should be tailored to protect information which should remain privileged.

In connection with the general discovery issues which we referenced above, however, we think Allison's most salient point relates to applicant's assertion in Allison that workers' compensation judges have no authority to enforce discovery orders (thus referencing the position of the workers' compensation judge that he has no authority to enforce an order compelling an appearance at a deposition). In response to applicant's argument, the court held that Labor Code §5310 empowers workers' compensation judges to decide discovery disputes, because they have the "powers, jurisdiction, and authority granted by law, by the order of appointment, and by the Rules of the WCAB, and that there is case law granting workers' compensation judges the authority to compel discovery".

If this is true (and it must be, since the Court of Appeals says it is), then a workers' compensation judge has no basis for stating that he/she has no authority or jurisdiction to enforce a discovery order (mostly, we see this in the context with a refusal to grant a petition to dismiss based on an applicant's refusal to participate in discovery). If the judge does not want to dismiss the case, he/she may fashion some lesser order to enforce compliance, but

they should not make the blanket claim that they don't have authority to do anything, because they certainly do.

With respect to the subject of Qualified Medical Examiners, we note with some disappointment a couple of panel decisions; the first of which is Chavez v. Miracle Farms, Case No. ADJ 9501859 (May 13, 2015) which held that, in connection with a dispute with respect to the specialty of the physician to be used (physical medicine and rehabilitation, as was applicant's PTP, or an orthopedist, as requested by defendant), applicant had the right to declare and designate the specialty (although how applicant held the right here is not really explained, since the defendant made the first request), the physical medicine and rehabilitation specialist was the appropriate choice.
Granted, as between an orthopedist and a physical medicine and rehabilitation specialist, the quality of the opinions may not be too much different (and we do not know what the issue was that really needed to be addressed here, although the issue will eventually be that of permanent disability).

However, the QME process as interpreted by many applicant's attorneys (and a lot of judges) is gamesmanship at its worst. We know of applicant's attorneys who select a chiropractor as their PTP (no matter what the injury), then immediately object to the chiropractor's report for the purpose of locking in a chiropractic panel. And why? One attorney was brazenly bragging in court to anyone who would listen (including the judge who was on the bench) that chiropractors always find industrial injury, and that he had conducted a study which demonstrated that a chiropractor's evaluation of permanent disability was generally over 50% higher than any other medical specialty.

Why would the Workers' Compensation Appeals Board not demand the most relevant and accurate medical evaluation and reporting available to it? If it is an orthopedic injury, the

evaluator should be an orthopedic surgeon; if it is an internal medicine injury, then the evaluator should be an internist. However, the way applicant's attorneys interpret these statutes and regulations (and the manner in which many judges agree with them), would quite literally permit these attorneys to designate a chiropractor to evaluate a cardiac case. And while we have heard one of the prominent advocates of the chiropractic school of thought suggest in the case the undersigned was litigating with him that that would never happen, what is to stop him?

To a certain extent, that is what makes a case like Riviera v. Jaco Environmental, 2015 Cal. Wrk. Comp. P.D. Lexis 58 (2015) even more disturbing. In this case, the PTP was a pain management specialist. Granted, defendant did not comply with the rule requiring the filing of documentation supporting a request for a physician specialty different than the primary treating physician, but why is the Board allowing a pain management specialist to evaluate every aspect of an orthopedic injury (especially with the order here that no future QME Panel should be issued without changes in circumstances)? Perhaps we are under the mistaken impression that this really is supposed to be a search for the truth.
In Chavez, the panel indicated "it is not clear that the WCJ had the authority to designate a specialty that neither party requested", but that, of course, is completely untrue. Reference the District Court of Appeals' observation of the workers' compensation judge's power in Allison, supra.

We previously referenced Ogden in the UR/IMR Section, relating to the right of cross-examination. Similar is Minh Ly v. Loral Space Systems, 2015 Cal.Wrk. Comp. P.D. Lexis 138 (2015), where applicant sought an expedited hearing following the termination of prescriptions through Utilization Review and IMR. The workers' compensation judge concluded that Patterson does not apply to prescription medication, and ordered the matter off calendar without allowing applicant to make a record. The panel decided that this was

a violation of applicant's due process, since, in order to properly consider and issue decisions, evidence had to be received on the record, along with any objections and arguments.

Finally, there is Arvizu v. Westac, Case No. ADJ 4280526, in which an applicant insisted that defendant should be ordered to prepay the cost of a vocational expert, it was held that the cost of a vocational expert is governed by Labor Code §4620, which defines medical-legal expense, and so it was payable as any other medical-legal expense; after it was incurred. It was noted that a defendant's willful and unreasonable delay or refusal to pay a medical-legal expense for which it is liable under §4520 (or Rule 10451.1) could rise to the level of sanctionable conduct under Labor Code §5813.

VIII.

DISABILITY PAYMENTS

Quite frankly, many of the disputes relating to temporary disability were resolved by the limitations on temporary disability which were set forth in Labor Code §4656(c), which essentially limited temporary disability to 104 compensable weeks (within various periods, depending upon the date of injury). Temporary disability is essentially defined as a substitute for lost wages during a period of temporary incapacity from working. *Wiggers v. WCAB*, 62 C.C.C. 248 (1997); *Ritchie v. WCAB*, 59 C.C.C. 243 (1994). An applicant is entitled to temporary disability pending completion of his doctor's evaluation of diagnostic tests (*Allianz Insurance Company v. WCAB*, 47 C.C.C. 416 (1982)), and he is entitled to a reasonable period of time in which to make a decision on whether to undergo serious medical treatment or diagnostic tests. *Ford Motor Company v. WCAB*, 40 C.C.C. 105 (1975).

Temporary disability is not apportionable. Thus, even if a nonindustrial condition prevents an applicant from receiving treatment (i.e., pregnancy), if the effects of the industrial injury are contributing to an applicant's temporary disability, then the applicant is entitled to be paid. *Ritz Carlton Hotel v. WCAB*, 62 C.C.C. 989 (1997); *California Casualty v. WCAB*, 42 C.C.C. 556 1977); *Fremont Medical Center v. WCAB*, 61 C.C.C. 110 (1996).

However, the criteria, as noted, is that temporary disability is a substitute for lost wages. If an applicant has no earning capacity then there is no entitlement to temporary disability. Thus, where an applicant generally retires from employment, and removes himself from the labor market, entitlement to temporary disability ceases. *Gonzales v. WCAB*, 63 C.C.C. 1477 (1998). *Gonzales* states that this inquiry is primarily factual, and one test is whether the worker is retiring from the labor market generally, or simply retiring from the particular employment in connection with which the worker was injured (more than likely, the temporary disability obligation is not going to stop if it is the latter).

Because temporary disability is a wage substitute, however, if an applicant is reasonably not working because of the injury, or because of treatment rendered in connection with that injury, then he is entitled to temporary disability. From a defendant's standpoint, a very unfavorable case is *Bucio v. County of Merced*, Case #ADJ9203286 (March 23, 2015). In this case, applicant's primary treating physician recommended a back surgery, which was decertified by Utilization Review. The applicant self-procured the back surgery (paid by his medical insurance) and claimed a right to temporary disability during his recuperation. The WCAB Panel held that he was entitled to temporary disability, noting that the Utilization Review process applies only to disputes regarding medical treatment services, and does not purport to apply to temporary disability. The Panel noted that, while a defendant is liable to provide medical care under Labor Code §4600, a injured worker is not obligated to utilize such medical treatment, and may select any attending and/or consulting physician he chooses at his own expense (and this would represent the principle set forth in *Valdez v. Workers' Compensation Appeals Board*, 78 C.C.C. 1209 (2013). The Panel advised that issue of temporary disability was to be addressed on its own merits, and not by consideration of the statutory process for addressing medical treatment disputes under Labor Code §4600.

An observation here, however, is based on the obvious assumption by the Panel that medical treatment is reasonable and necessary (in this case, the surgery was apparently successful). It is noted that Labor Code §4605 provides that a report prepared by a consulting or attending physician shall not be the sole basis of an Award of compensation (although in this case, we are not sure that the surgeon actually falls under this section, since it appears he was actually the primary treating physician).

Some other disputes with respect to the limitations on temporary disability came up in the context of Labor Code §4850 benefits payable to law enforcement officers (essentially, entitled to one year of salary in lieu of temporary disability). The initial issue was whether

this counted against the 104 week limitation set forth in Labor Code §4656(c), and in *County of Alameda v. Knittel*, 78 C.C.C. 81 (2013) the Court held that it was clear such benefits counted against the limitation.

Labor Code §4850 benefits are treated somewhat differently than temporary disability, however, in that the recipient is generally entitled to the full year of payments even if at maximum medical improvement (assuming that they have not returned to their usual and customary work), absent a disability retirement.

The limitations set forth in Labor Code §4656(c) are subject to several exceptions, the most litigated of which is related to the definition of amputations, although this was essentially resolved by *Cruz v. Mercedes Benz of San Francisco*, 72 C.C.C. 1281 (2007), which essentially decided that an amputation encompasses external projecting body parts, not internal parts, even if they include bone. A slight stretch on this, perhaps, was *Burrtec Waste Industries v. WCAB*, 75 C.C.C. 1175 (2010), wherein applicant's breast implants were damaged as a result of an industrial accident, with the result being that they had to be removed, resulting in an essential flattening of the breasts. The Court of Appeals held that this was an amputation, similar to what would be expected with a mastectomy. Given the circumstances here, that is an understandable opinion.

Before leaving this subject, a word about temporary disability overpayments. A defendant is not automatically entitled to credit for a temporary disability overpayment (and this most frequently occurs when temporary disability payments are paid subsequent to an applicant reaching maximum medical improvement, although there are other circumstances). Principles of estoppel may apply to cause the Board to deny the credit. One of the prominent examples of this is *Maples v. WCAB*, 45 C.C.C. 106 (1980) where an insurance carrier continued paying temporary disability benefits beyond (in fact, way beyond) the date on

which an applicant was determined to be at maximum medical improvement, despite having the physician's report to that effect, and without serving a copy of that report on the applicant until almost a year later (at which time it stopped the temporary disability and claimed the overpayment). The Court held that the failure to serve the medical report was a failure by the carrier to comply with its statutory obligations and administrative regulations to notify applicant of his workers' compensation rights and, under the circumstances, since applicant had no idea that he was not entitled to the payments, estoppel applied, and there was no credit.

One such statutory obligation is the obligation to object to disability status, if there is a dispute with respect to that. The defendant failed to make such an objection in *J.C. Penney Company v. WCAB*, 74 C.C.C. 826 (2009), where an applicant's primary treating physician continued to have an applicant temporarily disabled until the Agreed Medical Examiner declared applicant had actually been at maximum medical improvement about a year and a half prior. Because defendant had not been objecting to the disability status found by the primary treating physician, it was not entitled to an overpayment credit during the period of time it failed to make those objections.

The moral, we think, is that a temporary disability overpayment is not a sure thing. For that matter, before taking a credit for a temporary disability overpayment, defendant really needs an Order, and it has been held that a defendant unreasonably delays the payment of permanent disability indemnity when it does so because it believes it is entitled to claim a TD overpayment (absent an Order). *Woods v. WCAB*, 68 C.C.C. 88 (2002).

IX.

INJURY AOE/COE

Decisions with respect to the nature of employment are probably the biggest issues to be confronted in the upcoming years, primarily because of the change in nature of employment. Positions that for years were considered to be occupied by independent contractors are again coming to the attention of the Courts. The incremental inroad made by *Hassan v. County of Los Angeles*, 2015 Cal. Wrk. Comp. P.D. Lexis 18 (2015) seems to be a forerunner involving as it does an individual providing interpreting services for the County of Los Angeles. The County defended against her claim for industrial injury based on her being an independent contractor, citing a contract she had with the County to this effect. Although applicant was free to accept work from other entities, and had a contract which specified she was an independent contractor, she was required to call in to a call center for assignments; she was required to utilize certain forms for billing purposes; and the contract dictated her terms and rates. This does not sound like an awful lot (and there was a dissent), but for purposes of benefits, she was found to be an employee. There are a couple of Federal cases, *O'Connor v. Uber Technologies*, 2015 U.S. Dist. Lexis 30684 (2015) and *Cotter v. Lyft*, 2015 U.S. Dist. Lexis 30026 (2015), wherein the California Supreme Courts' eight factors to be considered in connection with the control of work (*Borello v. BIR*, 54 C.C.C. 80 (1989)) were found not to precisely fit the types of employments involved here (essentially, a somewhat informal, on call transportation service by which the drivers determined their own availability, and used their own cars). The Courts noted that traditional tests of employment which evolved under an economic model which was very different from the new "sharing economy" which exists today, appear outmoded, although the Federal Courts felt constrained to apply California Law in this regard.

There are limits to what will be accepted as an off duty personal conditioning program (where those are required by employers), as shown by *Simon v. City of Vacaville*, Case #ADJ9174605 (May 12, 2015), where applicant was hiking a very rugged trail with his Great Dane, which suddenly took off after something dragging applicant with him. The test was whether it is objectively reasonable for applicant to subjectively believe that the activity in which he was engaged when he was injured was covered by his individual fitness plan with his employer, or whether this was a voluntary participation in an off duty recreational, social, or athletic activity which barred recovery for injury pursuant to Labor Code §3600(a)(9). To a certain extent, this involves a factual question (and many of these cases seem to really stretch the envelope in favor of the employee). This one did not, since the plan had certain guidelines and safety recommendations to which the applicant did not adhere.

On the subject of presumptions, we are becoming more and more convinced that the heart injury presumption is about as irrebuttable as a rebuttable presumption can get. In *Suarez v. County of Santa Barbara*, Case #ADJ9065052, a deputy sheriff had a heart attack while engaged in a "work-related jogging routine". Every physician agreed that the heart attack was the result of a complete artery blockage, the result of a congenital abnormality, and the heart attack would have occurred no matter what applicant was doing. As a result of the anti-attribution clause in Labor Code §3212.5, it was held that this was not enough to rebut the presumption, since the defendant must show that the heart attack was the result of "some contemporaneous, non-work-related event".

X.
IN BRIEF

A. Apportionment. Commissioner Chairperson Caplane reminds us that, simply because the statutory scheme requires a physician to comment on apportionment does not mean that he has to find it, and if he does, he still needs to support that decision by substantial evidence. Thus, in Aima v. Buestad Construction, 2015 Cal. Work Comp. PD Lexis 62 (2015) the Agreed Medical Examiner generally apportioned a small amount of disability to a prior motor vehicle accident in 2003 (in connection with which the contemporaneous medical records suggested only a couple of weeks of treatment, and nothing else) and "degenerative changes". The ruling here was essentially that, just because an Agreed Medical Examiner says it, does not mean it is true. He still has to back it up with substantial evidence, and here he did not bother explaining the "how and why".

Perhaps what we should pay serious attention to is Dileva v. Northrop Grommens Systems, case number ADJ 1381123 (March 3, 2015), in which the orthopedic Agreed Medical Examiner apportioned sufficiently between a couple of industrial injuries, but the treating psychologist did not (apparently, there was no medical-legal psychological evaluation). The defendant argued that since the psychiatric injury was a compensable consequence of the orthopedic injury, it should have been apportioned in the same way but the WCAB panel disagreed, stating that the issue of apportionment required scientific medical knowledge, that the Appeals Board could not substitute its judgment for that of a medical expert, and that defendant had the burden of proof of apportionment, and failed to carry this burden. Thus, the result was a holding that applicant's overall permanent disability was inextricably intertwined, entitling applicant to a Wilkenson joint award.

B. Settlement. The observation here is that, if all of the recommendations we are hearing are followed, there are going to be very few Compromise and Release settlements. We are reminded that Medicare Set-Asides are limited in their ability to predict overall future medical care in a case, and that is true. The association encourages its members to consider the value of medical care outside of the Official Medical Fee Schedule (on which most MSAs are based), since it is unlikely that an applicant self-administering an MSA will be able to obtain those rates, deductibles which would apply to Medicare (particularly in the area of prescriptions), and so called "off the shelf" and other medical care which is not covered by Medicare.

The association also advises its members to participate in the negotiation of the Employment Development Department lien, so as to prevent the defense from limiting the reimbursements and thus ensuring that applicant's account is as fully reimbursed as possible.

These, of course, are deal breakers. Many MSAs themselves come back so high that Compromises and Releases are out of the cards on the basis of the MSA alone. It is all fine and good to claim that the $250,000.00 MSA is not nearly enough to cover all conceivable medical care, and that applicant needs a million dollars more, but most clients we represent are not going to pay that. They will stip the case, pay it out by the week, and take their chances on the medical care through the use of the utilization review.

Furthermore, we doubt that any good defense attorney (or their client for that matter) would tolerate interference by an applicant's attorney in connection with the negotiation of the Employment Development Department lien undertaken as part of the deal to close the case by way of a Compromise and Release.

In connection with an applicant being unable to obtain Fee Schedule rates in connection with treatment, this says more about the insistence of applicants and their attorneys that applicants self-administer their MSAs. MSAs are self-administered because applicants insist upon it. Realistically, however, how is some monolingual Spanish-speaking, limited education farm worker going to administer an MSA? Quite frankly, most attorneys probably are not competent to do it. To truly and properly administer an MSA, a professional probably needs to do it, but, then, that would deprive the applicant of unfettered access to the funds (and we do not want to be cynical about this, but realistically that is what it is all about).

C. Regulations. As of January 1, 2015, new copy service regulations go into effect (Regulations 9980 through 9984). The basic fee for copying is $180.00. It does appear that obtaining records from the WCIRB and EDD will be allowed, although the maximum fees would be $30.00 for the WCIRB and $20.00 for EDD.

Still in the works are proposed regulations amending the medical treatment utilization schedule, QME Panel requests (primarily in connection with the electronic request system in represented cases), home health care, and interpreters (refining, somewhat beneficially for the defense, we think, the fees chargeable for medical treatment appointments). These regulations are still in their respective comment periods, and it is unclear when the final regulations will eventually be adopted.

D. Post script. Subsequent to the convention, the United States Court of Appeal for the Ninth Circuit issued its opinion in Angelotti Chiropractic v. Baker (06/29/15) the effect of which was to reinstate the lien claimant activation fee. More than likely, there will be a grace period for payment but the DWC mechanism for accepting

payment does not seem to yet be in place. Lien Conferences are being continued to accommodate this. There is talk of a U.S. Supreme Court Appeal but we have doubts that Court would be interested.

XI.
CONCLUSION

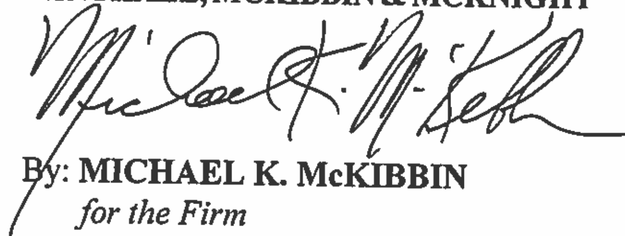
Perhaps greatest interest in the near future will be the new regulations, particularly as they relate to home health care (these will include not only a utilization schedule, but a fee schedule as well) and interpreting fees (the proposed drafts would reduce the minimum time for a medical treatment appointment to one hour, and would eliminate travel time). Needless to say, CAAA has a lot to say about these regulations.

We expect that there will probably be some significant decisions with respect to IMR in the near future as well. The entire system appears to be under attack in the Stevens case, and we would not be surprised to see the Court of Appeal take up the issue of remedies in the event of untimely independent medical review decisions.

We hope you find this report helpful. If you wish us to provide any presentations with respect to the topics contained in this report, or any other topics in which you have interest, we would be more than happy to do so, and encourage you to contact us with respect to this.

Very truly yours,

BENTHALE, MCKIBBIN & MCKNIGHT



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