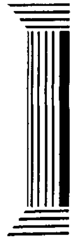

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THE DEFENSE PERSPECTIVE AND OBSERVATIONS OF THE CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION 2013 SUMMER CONVENTION

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2013 SUMMER CONVENTION OF THE CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION JUNE 27-30, 2013

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I.
INTRODUCTION

To our clients:

The California Applicant's Attorneys Association held their 2013 Summer Convention on June 27 – 30, 2013, and we were in attendance. The sudden shock of the adoption of Senate Bill 863 appears to have worn off, and the primary focus of this convention appeared to be simply dealing with the new legislation. There was, of course, the concern expressed with respect to how to maximize benefits, especially in light of the elimination of certain types of compensable consequences, but, interestingly enough, the primary and recurring theme in this convention related to the new importance of utilization review in light of the universal application of independent medical review to all cases beginning on July 1, 2013.

There is, of course, applicants' attorneys' ongoing distrust of utilization review. And there appears to be another underlying current of concern that independent medical review will be nothing but a rubber stamp. The independent medical review contractor engaged by the administrative director is an organization called Maximus Federal Services, Inc., with a base of operations in Reston, Virginia, although the local office is apparently in Folsom, California. Concern was expressed that the independent medical reviewer might not be from California or licensed in California, or even familiar with the local standards of medical care, but this may be far fetched. Indeed, the seminar materials included several independent medical reviews conducted since the advent of the program (it is has been effective for injuries occurring on or after January 1, 2013), and those reviewers were California licensed physicians (although they remained anonymous), and the few examples provided showed a ready willingness to overturn what were considered overly restrictive utilization reviews.

There also seems to be a guarded optimism that the Workers' Compensation Appeals Board is accepting an expanded view of disability rated under the AMA Guides. Guzman is not discussed so much in terms of authorizing a rebuttal of the Permanent Disability Schedule, as simply explaining how the AMA Guides are to be interpreted in formulating a rating under the Permanent Disability Schedule. This, of course, attempts to avoid the defense argument that rebuttals of the Schedule should be narrow exceptions.

In our prior analysis of CAAA's 2013 Winter Convention, we did provide an extensive review with respect to the new rules relating to utilization review and the upcoming IMR. We will build on that in this paper. Our prior articles can be accessed through the firm's website at **www.benthalelaw.com**.

II.

UTILIZATION REVIEW AND INDEPENDENT MEDICAL REVIEW

A. In General

Labor Code § 4610(b) provides that every employer shall establish a utilization review process. By statute, as of July 1, 2013, the utilization review process will be pretty much removed from the adjudicatory process of the Workers' Compensation Appeals Board, and will instead be administered through the Administrative Director's office by way of a process called independent medical review. There is a belief among many applicants' attorneys that carriers will attempt to use the utilization review/independent medical review process to thwart medical care, but we think this is a fallacy. While we believe that most claims administrators have no designs to thwart an honest entitlement to benefits, we think the sheer cost of engaging in an independent medical review may well cause carriers to take a practical approach to the authorization of medical treatment, even in the face of an adverse utilization review. It is our understanding that the review costs for each independent medical review requested will be $560.00 for a basic review, and $685.00 for an expedited review, so, in determining whether IMR is an option, we think that defendants will probably give weight to the persuasiveness of the utilization review, and the ultimate cost and consequence of the medical care itself. In other words, if the fight is over a questionable $600.00 MRI, it might well be more cost effective to simply authorize the MRI, and save the review money for more important big ticket items.

B. Procedural Adequacy

That being said, the CAAA groundswell appears to be focused on finding ways to avoid IMR, and this involves attempting to invalidate the utilization reviews themselves. This is a matter of concern, as one of the panelists, Workers Compensation Judge Rosa Moran, who has apparently developed some expertise in what is required for a valid utilization review, comments that about 90% of utilization reviews that come

before her are invalid because of various procedural defects (and there are plenty of ways to go wrong). The first and foremost criteria relates to the timeline. The timelines are strict, and while there appears to be an assumption that defendant has up to 14 days in which to accomplish a utilization review, that is wrong. In the normal case, initial action by the utilization reviewer must be taken within "five working days" from the receipt of the information reasonably necessary to make the determination (Labor Code § 4610(g)(1)). As of July 1, 2013, what triggers this obligation is the carrier's receipt of the request for authorization (Regulation § 9792.9.1 sets forth the rules when the RFA is deemed to be received, and when the countdown begins). The 14-day period only comes into play if the utilization reviewer has not been provided with sufficient information to make a decision on the merits. In such a case, the delay must be communicated to the requesting physician within five working days of the receipt of the RFA, and at that point, a final decision of some sort has to be made within the initial 14-day period (but the decision can never be made more than five working days after sufficient information has been received). If these timelines are exceeded, the utilization review is invalid.

The timelines are even shorter with respect to the situation where "the employee faces an imminent and serious threat" to health, in which case the timeline is shortened to 72 hours after receipt of the information necessary to make the decision (Labor Code § 4610(g)(2)).

The timelines, of course, are not the only pitfalls. Others relate to untimely communications to the physician or employee (24 hours with written confirmation, either within 24 hours and/or two days depending upon whether it is concurrent or prospective review), untimely notification that additional material is needed; the utilization reviewer has not been provided with all medical records in the control of the carrier necessary to perform an adequate review (we probably see this a lot) or inappropriate criteria is used in making the decision (the primary criteria would be the Medical Treatment Utilization Schedule of the Administrative Director, but this is not the exclusive basis) (all these

requirements are set forth under Labor Code § 4610 and Regulation 9792.9.1). The consequences of a procedurally defective utilization review can be severe.

The cases of State Compensation Insurance Fund v. Workers' Compensation Appeals Board (Sandhagen), 73 C.C.C. 981 (2008) and Willette v. Au Electric Corporation, 69 C.C.C. 1298 (2004) essentially stand for the proposition that "administrative remedies" must be exhausted before resorting to the Workers' Compensation Appeals Board for resolution of a treatment dispute. At the time these cases were decided, IMR was not a part of the picture, but the idea was that the employer's method of dealing with a treatment proposal was by way of utilization review as required by Labor Code § 4610 and, if the employee was unhappy, the employee then resorted to the medical-legal provisions of Labor Code § 4062. These cases, however, are based upon the assumption that the utilization review is procedurally adequate. If it is not, the general rule (we say this is a general rule because we think there is a possibility, as noted below, that an applicant may be held to waive procedural defects) is that the utilization review is "inadmissible". Under these circumstances, an employee is not required to challenge the utilization review administratively (which would include a challenge through IMR [Labor Code § 4610.5 and 4610.6]), but is able to proceed directly to the WCAB by way of an expedited hearing. In Corona v. Los Aptos Christian Fellowship Childcare, 2010 Cal. Wrk. Comp. P.D. LEXIS 459 (2012), a panel decision, the Board held it was appropriate for an injured worker to challenge a utilization review based upon procedural deficiency by resorting directly to an expedited hearing. And in Becerra v. Jack's Bindery, 2012 Cal. Wrk. Comp. P.D. LEXIS 451 (2012), in the context of a previously issued award which contained provisions for future medical treatment, it was held that a procedurally deficient utilization review would expose the defendant to a supplemental award of attorneys' fees under Labor Code § 5814.5.

Quite frankly, while we were surprised by Judge Moran's estimate that 90% of utilization reviews she has seen were deficient in some way, we have similar concerns with a number of reviews that we have seen in our practice. While these reviews may be

sufficient to use against lien claimants, who are perhaps not as sophisticated, applicants' attorneys will, unfortunately, be taking a much closer look at them. We have noted utilization reviews where the utilization reviewer has apparently not had access to reporting of the Agreed Medical Examiner, or a Panel Qualified Medical Examiner, in making decisions, and that is going to cause a real problem. The lack of relevant medical information in the utilization reviewer's possession is going to lead to a claim that the utilization review is not supported by substantial evidence, is therefore technically deficient, and thus allowing an applicant to proceed directly to an expedited hearing without availing himself or herself of independent medical review.

This does not necessarily mean that the treatment being proposed by the treating physician will be automatically authorized. As Judge Moran points out, the treatment request itself must be supported by substantial evidence (See Corona).

Assuming there is a valid utilization review, and an applicant's only alternative is independent medical review, there are still multiple requirements of the carrier as set forth in Labor Code § 4610.5. At the time the adverse decision is communicated to the employee and physician, in addition to the detailed decision requirements, applicant must be provided with a fully completed IMR application and, assuming the employee follows through, there are then multiple requirements on the carrier with respect to timeframes, documents to be provided to the independent review organization, and penalty and sanction provisions in the event of non-compliance (Labor Code § 4610.5). Applicants' attorneys have spoken in terms of submitting advocacy letters, attempting to explain the medical issues and community standards for treatment, but this is likely to be somewhat difficult since the actual identity of the independent medical reviewer is never disclosed (his qualifications are the only thing which are disclosed). Quite frankly, the method by which this takes place would mean such an advocacy letter would have to go through the independent medical review organization (Maximus), and we seriously doubt that the organization will forward anything to its doctor beyond the material which is specifically described by the statute (essentially, medical reports and records).

There are limited appeal rights (essentially, a verified petition, Labor Code § 4610.5(h); and Regulation 10957.1). However, the Workers' Compensation Appeals Board cannot make a determination on the merits of treatment contrary to the independent medical review decision (which is deemed to be the decision of the Administrative Director). Labor Code § 4610.6(h).

Because of the timelines involved, applicants' attorneys have suggested challenging adverse treatment decisions in the alternative: filing not only the Declaration of Readiness to Proceed requesting an expedited hearing, but also pursuing the independent medical review process. We were wondering, however, whether this may create a waiver problem for applicants, especially if the IMR process is somehow completed before the expedited hearing. Under those circumstances, defendants may be able to argue that, by submitting to the IMR process, and obtaining a decision, that applicants have waived any procedural defects with respect to the utilization review, and are now bound by the IMR decision. This would especially appear to be true in light of the statutory provisions to the effect that the Workers' Compensation Appeals Board cannot make a determination on the merits contrary to a decision of the independent medical reviewer.

C. Disputed Conditions

Labor Code § 4610(g)(7) provides that utilization review of a treatment recommendation may be deferred if the employer is disputing liability for injury or treatment to the condition for which treatment is recommended, and subsection (g)(8) provides that, if there is such a deferral, and it is eventually determined that the employer has liability, retrospective utilization review must then be conducted, with a timeline for such review beginning on the date that the employer's liability becomes final (30 days from receipt of information reasonably necessary to make the utilization review, §4610(g)(1)). Deferral of utilization review for such conditions requires some fairly specific action under Regulation 9792.9.1(b). The timelines are essentially the same as they are for utilization review. The decision must be communicated within 5 business

days of receipt of the RFA, with a written decision being sent to the requesting physician, the injured worker, and the attorney, and setting forth very specific information: the date the RFA was received, description of the course of treatment, a detailed reason for the claims administrator's dispute of liability "for either the injury, claimed body part or parts, or the recommended treatment", advice with respect to the dispute resolution process (Labor Code § 4062) plus certain mandatory boilerplate language (Regulation § 9792.9.1(b)(1)(E)).

The Regulation actually suggests that this process is required not only where there are disputed body parts, but also in cases where liability for industrial injury is denied in its entirety. Quite frankly, in the latter case, we would think that the general denial of liability letter would be sufficient, and would certainly argue that. However, it is clear that this rather complex response to a RFA is certainly going to be required in connection with disputed body parts. Almost certainly, the utilization review deferral notice should probably be accompanied by a Labor Code § 4062 objection, so as to start the medical-legal wheels in motion with respect to a determination of the dispute.

III.

ROLE OF THE MEDICAL-LEGAL EVALUATION AND DISCOVERY

The particular concern with respect to medical-legal evaluators relates to the ability of the evaluator to comment on ongoing treatment. Labor Code § § 4062(b) and (c), and 4062.2(f) provide that the medical-legal process does not apply to utilization review (current treatment) issues reviewable under Labor Code § 4610.5; see also Regulation 35.5(g)(2). It is clear that the Agreed Medical Examiner or Panel Qualified Medical Examiner is authorized to discuss future treatment needs in the general sense, and the panelists are suggesting that these evaluators certainly be encouraged to discuss ongoing treatment needs, since it is clear that all Agreed Medical Examination and Qualified Medical Examination reports are to go to either the utilization reviewer or to independent medical review, and we think this is a valid suggestion.

More important is the question of whether or not the Workers' Compensation Appeals Board would defer to the opinion of a Agreed Medical Examiner or Panel Qualified Medical Examiner where the parties had requested that evaluator to make the decision with respect to treatment (as opposed to utilizing the IMR process). Judge Moran pointed out that Senate Bill 899 contained provisions prohibiting the use of an Agreed Medical Examiner after a 10 to 30 day window, purporting to then restrict the parties to the use of a Panel Qualified Medical Examiner. She notes that, to her knowledge, an agreement between the parties to utilize an Agreed Medical Examiner after this window had expired had never been invalidated (even in the face of a new attorney assuming representation for a party, and attempting to invalidate the agreement on the statutory basis, although she noted this would be a concern). She points out that, in order for the workers' compensation system to actually work, the parties must attempt to make agreements and, when agreements are made, the parties must then honor those agreements. Thus, it is her feeling, that if the parties agree to allow the medical-legal evaluators to make decisions with respect to ongoing treatment, then those parties will then be bound by the results of their agreement.

IV.

INTERPRETATION AND REBUTTAL OF THE AMA GUIDES AND PERMANENT DISABILITY RATING SCHEDULE

Rebuttal of the Permanent Disability Rating Schedule continues to take two distinct approaches, those relating to the AMA Guides component relating to the actual impairment, and those relating generally to employability (the diminished future earning capacity component, although that component has been eliminated with respect to injuries occurring after January 1, 2013. [Labor Code § 4660.1]).

A. Impairments

With respect to the actual impairments under the AMA Guides, the guiding light is Milpipas Unified School District v. WCAB (Guzman), 187 Cal. App. 4th 808, 75 C.C.C. 837 (2010), fortified by Labor Code § 4660.1(h) stating that the legislature had no intention of overruling Guzman, which essentially gives it a legislative seal of approval.

It appears that applicants' attorneys are seeing Guzman as being not so much a rebuttal case, as an interpretation case. In other words, the idea is that Guzman is not so much about how the AMA Guides are to be rebutted, as it is how the Guides are to be interpreted, especially in light of the instructions contained in the first two chapters. In our practice, where we have had the opportunity to submit advocacy positions to medical-legal evaluators, we have taken the position that a strict interpretation of the specific Tables relating to the medical condition is the proper impairment to be applied under the Permanent Disability Rating Schedule, and that as long as that impairment analysis is "accurate", rebuttal under Guzman is improper. Applicants' attorneys appear to be taking the approach that Guzman actually requires the use of an impairment which is "most accurate". They argue that this is the only rational method by which the Guides can be used, otherwise there are irreconcilable inconsistencies, noting that the Guides, making reference to an activity restriction, gives a person with a hernia who cannot do heavy lifting a 19%, but without a reference to activity restrictions, gives a person with a back

injury, who has the same type of restriction, only 8%. This type of approach, unfortunately, makes a certain amount of sympathetic sense.

Thus, in Ferris v. United Airlines, 37 C.W.C.R. 99 (2009), the Workers' Compensation Appeals Board endorsed using Table 6-9 with respect to hernias for the purpose of rating applicant's disability (essentially, a restriction against heavy lifting), reasoning that the DRE method did not reflect applicant's true lost earning capacity.

In Scotts Jack London Seafood v. WCAB, 76 C.C.C. 1348 (2011), the WCAB also felt that reference to the hernia chapter was appropriate for a back injury, in which the DRE method did not take into consideration applicant's gait derangement and activity restrictions.

Granted, this is creeping (perhaps more than creeping) back to the old work restriction method endorsed by the 1997 Permanent Disability Schedule. On the other hand, perhaps the difference is whether or not the activity restrictions are actually "prophylactic". It is unclear whether the activity restrictions set forth in the hernia section of the Guides are actual (a person simply cannot perform the activity from a physical standpoint), or prophylactic (a person should not perform the activity, as this creates a danger of further injury). If these are actual restrictions, then perhaps there is not so much bleeding over into the old Schedule.

It is clear from Guzman that certain criteria in the Guides may be used even in the face of cautionary statements from the Guides, so long as there is an adequate explanation. See Hyatt Regency Hotel v. WCAB, 73 C.C.C. 524 and Cortez v. Zurich North American, 36 C.W.C.R. 41 (2007), both holding that, despite the Guides recommendation that grip loss was subjective, it was appropriate to rate the case based on grip loss because it was well documented, and resulted in a more accurate rating.

We also note Laury v. State Compensation Insurance Fund, 39 C.W.C.R. 67 (2011), where the Board appears to endorse a functional loss approach to a spinal impairment based on the reference to figure 15-19 of Chapter 15 of the Guides, based

upon the AME's opinion that the DRE was inadequate, and that it was his best medical judgment the applicant had lost a certain percentage of function in the spine.

Quite frankly, these latter cases (Hyatt, Cortez, and Laury) are the ones with which we probably have least difficulty, since the rebuttals/interpretations of impairment are at least within the Chapters which relate to the specific body parts at issue. Perhaps these are the actual "interpretations". The true rebuttals would be by reference to Chapters relating to other body parts (Ferras and Scott).

B. Employability

Quite frankly, we think Ogilvie has probably lost its relevance, except perhaps to the extent that it tends to validate LeBoeuf.

The employability rebuttal essentially relates to the vocational issues involved in an applicant's disability. No one is quite sure what effect Labor Code § 4660.1 is going to have on the ability to present this type of testimony, although it could probably be said with confidence the general LeBoeuf type principles will continue to apply (and this will probably be in the context of total disability cases, since the showing after January 1, 2013, that an applicant has less earning capacity than that set forth in the Schedule will be largely irrelevant). The impression we have in following the cases is that, at least at this point, the Board is requiring a somewhat exacting standard before it is willing to follow a vocational rebuttal. In Alda Mrozek-Payne, an August 17, 2012 Panel decision (Case No. ADJ4451171), the vocational expert took the position that a GAF score of 45 suggested such severe impairment that applicant would be considered totally disabled. Noting that the expert had not met with applicant, had not conducted a formal work evaluation, and that the two AMEs in the case had not suggested total disability, the Board found this opinion lacked substantial evidence. Even in connection with LeBoeuf, we have always felt that the first step to finding total disability had to be a medical opinion to that effect, and that the vocational evaluation must be based upon that.

In terms of how the evidence is to be presented, an approach which was recently used was bringing the vocational expert to the cross-examination of the rater, and having

him offer his testimony attempting to rebut the rating at that time. Charter Communications v. WCAB, 77 C.C.C. 1132 (2012). While that approach was validated in the context of the time in which it occurred, Labor Code § 5703(j) generally requires that vocational evidence be submitted by way of report, rather than live testimony, and specifically provides that continuances are permissible for the purpose of rebuttal.

In this regard, we have been somewhat amazed at the position of several prominent applicants' attorneys who have taken the position that a defense vocational evaluator has no right to interview their client (or, indeed, even review relevant medical reporting) for the purpose of rebutting an applicant's evaluation (a contention which seems to run completely afoul of elementary due process; no matter how much attorneys tend to sugarcoat it, it appears to be a blatant attempt to prevent the employer from defending itself). That contention appears to be put to rest by Holz v. Gottchalks, 41 C.W.C.R. 41 (2013), holding that if applicant is retaining a vocational expert, the defense expert is entitled to a personal evaluation of the applicant for the purpose of rebuttal. Referencing the contention that this invades applicant's privacy, the Board had indicated applicant waived that right by raising the earning capacity issue in the first place.

V.

COMPENSABLE CONSEQUENCES

This could prove to be a fertile area for litigation, as there is still much discussion by the applicants' bar with respect to methods of attempting to circumvent Labor Code § 4660(c) (no increases in impairment ratings for sleep dysfunction, sexual dysfunction, or psychiatric disorder arising out of compensable physical injuries except in cases of exposure to a violent act or catastrophic injury). The theory here, according to Panelist Mark Kimmel, Ph.D., is that this section embodies an outmoded 17th Century approach to injury which ignores the fact that an injury involves an alteration to all parts of the anatomy and physiology. In effect, since pain is manifested in the brain, there is no real division between mind and body, and the effects of pain can be characterized as a post-traumatic stress disorder which involves a direct psychiatric injury (as opposed to a consequential one). In other words, the condition is to be analogized as a head injury (or traumatic brain injury) ratable under Chapter 13 of the AMA Guides, rather than a consequential psychiatric injury. The idea is to redefine a head injury or brain injury as "an injury or trauma to the brain resulting in cognitive impairment", and then attempting to rate the cognitive symptoms such as retention problems, concentration problems, memory problems, orientation problems, headaches, dizziness, insomnia, fatigue, and such behavioral changes as irritability, depression, anxiety, or sleep disturbance.

If we are dealing with what has commonly been understood in the past as a compensable consequence, this is bogus, and we think most intelligent judges will see it for what it is: an attempt to circumvent legislative intent. Applicants' attorneys feel they can get this evidence in by virtue of the provision in Labor Code § 4660.1(c)(1) to the effect that there is nothing in this section which limits the injured employee's ability to obtain treatment for these conditions, and thus applicants' attorneys feel that they will be able to obtain medical reporting with respect to them. However, we think we can certainly attempt to discourage this by arguing that the statute certainly limits the ability

of a physician to submit medical-legal reporting in connection with the impairment and/or disability issue.

There was also a suggestion that may it may be possible to circumvent the statute by pleading a specific physical injury in conjunction with a cumulative trauma alleging a direct psychiatric injury (although we are curious with respect to how this is done if there is no evidence of a direct psychiatric injury, such as harassment). The idea is to "fold the disabilities together" by way of a medical-legal opinion that the physical injuries and psychological injuries are so "inextricably intertwined" that it is speculative to pull the dates of injury apart. This, of course, is ridiculous. We are talking about two completely separate body parts here, and it should be fairly elementary for anyone to separate the disability which is attributed to each body part.

The so-called "impact" cases present a different situation. These are cases which would involve a physical injury to the head (or brain, for that matter), so, even though there is a physical injury (fractured skull, spinal injury, etc.), it may also be said under these circumstances that there is a direct psychiatric injury. The medical evidence is going to have to show that the psychiatric injury arose directly from the event itself, rather than being caused from the affects of the physical injury (depression with respect to financial condition, ongoing pain, etc., the true indicator of a consequential injury).

VI.

SETTLEMENTS AND MEDICARE

A. The MSA

The initial focus of the settlement panel is with respect to those cases which had been partially closed by way of permanent disability awards. The panelists state that these cases, even those in connection with which reopening is barred by time, may have significant settlement value in connection with what is required by way of future medical care. Even in these cases, compensable consequences to body parts which were not a part of the original injury can still be raised in connection with medical care which may be required, and there is a suggestion that the creation of life care plans and home assessments be utilized for the purpose of establishing the value of future medical care independent of the value of any remaining disability.

The panelists suggested that the cost of such studies are valid medical-legal expenses which should be borne by the defendant, but we are not so sure (at least in terms of cases where there are existing awards). There is no obligation on the part of either party to settle a case by way of Compromise and Release. If an applicant unilaterally obtains a life care plan or home assessment without some authorization (or even interest by the defendant in connection with a Compromise and Release), why should that be considered a reasonable medical-legal expense for which the defense should be liable? This is especially true in the face of the argument that the applicant should be entitled to utilize their own hand-picked life care planner as opposed to anyone who might be suggested by the defense.

If there is going to be defense liability for the cost of coming up with such plans, we think it can only be the product of an agreement that a Compromise and Release is something which is desired by both sides, an agreement with respect to the scope of the plan which is going to be created, and the identity of the person who is going to create it.

The greatest difficulty with respect to settlements in recent years has been MediCare. As defendants, most of us, even in the simplest of cases, want statements in

our Compromises and Releases to the effect that applicant is not a MediCare recipient or applicant. The Workers' Compensation MediCare Set Aside arrangement (WCMSA) reference guide published by CMS (March 29, 2013) defines MediCare as a "secondary payor" in connection with workers' compensation injuries (i.e., another entity has primary responsibility for medical care), noting that MediCare may not pay for a beneficiary's medical expenses under 42 U.S.C. § 1395y(b)(2) and § 1862(b)(2)(A) where payment either has been made or can reasonably be expected to be made under a workers' compensation plan. MediCare will make "conditional payments" where the claim is in dispute, but expects the money back when the dispute has been resolved. It is noted that all workers' compensation occurrences involving a MediCare beneficiary should be reported to the Coordination of Benefits Contractor (COBC). Where MediCare is involved, it is required that MediCare's interest be taken into consideration in connection with the settlement of a workers' compensation claim (with limited exceptions relating to disputed claims, known as "compromises").

The basic thresholds are as follows:

1. Any settlement where applicant is a MediCare beneficiary, although CMS will review set-asides and render approvals only where the total settlement amount is greater than $25,000.00.

2. Claimant has a reasonable expectation to MediCare enrollment within 30 months of the settlement date, and the amount is greater than $250,000.00.

MediCare does not discount estimated future medical expenses for present value, but insists upon assigning full value to those expenses. Applicants' attorneys have expressed concern that in a number of cases, the proposed cost of a MediCare Set Aside has been so high as to discourage Compromise and Release settlements. Methods of addressing this involve limiting the body parts (you have to wonder what some applicants' attorneys are thinking by pleading routine "skin and contents claims", since MediCare is going to take all of this into consideration), or attempting to convince the physician to whom MediCare will give the most weight (Agreed Medical Examiners for example) the

certain treatment modalities may not necessarily be necessary. What is not effective (and we know this to be the case) are statements from an applicant to the effect that they will not seek the medical care which has been suggested as an option.

CMS approval of a proposed Workers' Compensation MediCare Set Aside is never required. The only requirement is that MediCare's interest be fairly taken into consideration. Without an approval, however, there is no guarantee that MediCare will deem that its interests have been fairly considered when the time for the making of that determination comes, usually when an applicant is attempting to access a MediCare payment. The consequences for failing to take MediCare's interest into consideration primarily affect the injured worker, and are significant: MediCare may refuse to pay for future medical expenses related to the workers' compensation injury until the entire settlement is exhausted (MediCare has actually taken the position that it might refuse to pay for any medical expenses until the settlement is exhausted). If MediCare were to pay such expenses, it asserts a right of recovery against any person who directly or indirectly received the proceeds of the settlement.

The MSA process is, unfortunately, a very cumbersome one. CMS is taking extraordinary lengths of time to approve MSAs, while settlements hang in limbo. There is, fortunately, some movement towards attempting to streamline this process (See 41 C.W.C.R. 109 (June 2013)). These new regulations would streamline the period for which CMS to act on a MSA (CMS would have 60 days, or the MSA would be deemed approved), and would also establish an appeals procedure in the event the parties were unhappy with the CMS approval. The regulations would also exempt settlements under $25,000.00 from the requirement that Medicare's interest be taken into consideration (at present, while CMS will not review such settlements, this is not a "safe harbor", as Medicare's interest must still be taken into consideration). For the purpose of simplifying the administration of MSAs by workers (most of whom are probably incompetent to administer the MSA in any event), the new regulations would require CMS to accept payments (which would then be used by MediCare to pay for expenses), and it would also

establish a general safe harbor by which an applicant could agree to pay 15% of the gross settlement to CMS to satisfy MediCare's interest in the settlement.

B. Non MediCare Aspects of Settlement

We all look forward to this. One panelist said perhaps we will see the implementation of these regulations in the next two years. They can't come soon enough.

From a defense standpoint, we like to think that the MSA represents, if not all, at least a majority of the defendants' future medical care obligation. CAAA panelists are contending this is not the case. First, they point to the various MediCare deductibles (MediCare Parts A & D (physicians and hospitalization) generally require 20% co-pay, while Part B (prescriptions) provides for deductibles, a so-called "donut hole" (100% liability for yearly expenses between $2,971.00 and $4,750.00), as well as a co-pay).

It is in connection with this that life care plans are encouraged, so as to show the cost of non-MediCare expenses (we have seen several MediCare vendors provide estimates of non-covered medical expenses over the course of an applicant's life, and some of these life care plans significantly exceed the cost of the MSA).

Again, everything must be rooted in reality. Even some of the foremost proponents of valuing medical care for the purpose of the settlement caution that where the future medical tab gets too high, defendants will simply deal with the award.

Although, as defendants, we do not have much exposure with respect to the Subsequent Injuries Benefit Trust Fund, we may find that entity entering the picture in connection with some of our settlement negotiations. To a certain extent, we may be able to use this entity in connection with our own negotiations, if applicant's attorney has a belief that the fund will be available for additional benefits in addition to the case in chief. Basically, the threshold for subsequent injury fund involvement is an industrial injury rating at least 35%, with overall disability (from the industrial injury, in combination with something else) of 70% or better. Thus, the 35% is a magic number for applicant's attorneys, where there is potential involvement of the fund.

VII.

LIENS

In listening to the commissioner's report, it is still clear that liens are a somewhat sensitive topic. They still appear to crowd the docket, and Commissioner Caplan suggested that the quality of documents which they receive from lien claimants on appeal is not nearly up to the standard which they would expect.

Regulation 10770 relates to the filing of lien claims. It requires payment of activation fees (for liens prior to January 1, 2013) or filing fees (for liens filed thereafter). The Regulation provides that "medical-legal costs" are not allowable as liens against compensation, although they may be filed as a lien claim. Liens which are not statutorily allowable are essentially ignored. Presumably, this includes medical treatment liens for treatment provided after January 1, 2013, where the only dispute relates to the cost of medical care either related to a form of medical treatment subject to IMR, or which is subject to the independent bill review procedures set forth in Labor Code §§ 4603.2, 4603.3 and 4603.6. (Regulation 10770(c)(7)).

Lien claimants used to argue against the application of the statute of limitations by contending that the defendant had an obligation to file their lien claims at the time of settlement (a contention which is certainly not being made in this day of filing and activation fees). Subsection (c)(10) specifically states that the defendant has no such obligation, and subdivision (c)(9) specifically provides that the service of a lien claim on a party does not constitute filing.

Regulation 10770.1(a)(2) provides that lien conferences and lien trials can be set in any venue designated by the WCAB, based upon resources available, without the necessity of an order changing venue. Conceivably, a San Diego lien could be scheduled for conference in Redding, although we would like to think the Board would be more practical. Regulation 10774.5 relates to the requirement that lien claimants file and serve notices of representation, and the time within which such notices must be filed.

What has caused lien claimants the most consternation since the beginning of the year has been the activation fee. Commissioner Caplan noted the most common excuse they see on reconsideration for not paying the activation fee is that "EAMS" was down, an excuse which she says does not work. Thus, we have cases such as Figueroa v. Employers Compensation Insurance Company, 78 C.C.C. ____ (2013) and Mendez v. Le Chef Bakery, 78 C.C.C. ____ (2013), noting that Labor Code § 4903.06(a)(4) mandates dismissal with prejudice of a lien where the lien activation fee has not been paid prior to the commencement of a lien conference, (although a lien trial is not considered to be a triggering event here). Martinez v. Allstate Insurance Company 78 C.C.C._____(2013), holds that a medical-legal expense is subject to the lien process, may not be filed as a petition for cost under Labor Code § 5811, and that the activation fee applies. Martinez is related to a copy service lien. There is still some uncertainty with respect to interpreter liens, and although we certainly agree there may be some room for argument with respect to those interpreter liens which are related to the adjudicatory process (interpreting fees incurred at hearings, depositions, Agreed or Panel Qualified Medical Examinations), there is absolutely no reason why interpreting liens relating to medical treatment should be treated any differently than a medical lien.

On the subject of the MPN, the very recent case of Mendez-Correa v. Zenith Insurance Company, 41 C.W.C.R. 118 (2013) considered what we thought was a very well analyzed decision and opinion from Judge Zamudio at the Van Nuys Board. Judge Zamudio presided over the trial and decided, among other things, that Defendant Zenith had a valid MPN, that applicant had self-procured a physician outside of the MPN, Zenith was therefore not liable for the expense related to the treatment provided by the self-procured physicians, and that applicant was responsible for the cost of that medical care. All of this appears to be literally what is required by statute where an applicant abandons the MPN for self-procured treatment.

We assume the WCAB felt some political tinkering was required here. Noting that applicant had been referred to the self-procured doctor by her attorney, the Board imposed the additional requirement that, at the time of the referral, applicant must have intended to personally pay for the treatment and, in the absence of such intent, an order requiring applicant to pay for the treatment was unjustified. Significantly, Judge Zamudio's order exonerating Zenith from liability was not disturbed, and the 35 lien claimants (that's right 35) are left holding the bag. What a shame.

In closing out this section, there is a somewhat disturbing opinion with respect to the Fee Schedule, that being Enriquez v. Zenith Insurance Company, 78 C.C.C. ___ (2013), an en banc decision holding that the Official Medical Fee Schedule is preempted by the Airline Deregulation Act of 1978 insofar as it applies to an air carrier providing interstate air transportation. In this case, the carrier that claimed the benefit of such a preemption was Mercy Ambulance, which provided an air ambulance to applicant at the time of his injury, and charged Zenith $11,132.93. Applying the Fee Schedule, Zenith paid $4,756.42, and Mercy claimed exemption from the Fee Schedule, and litigated a lien for the balance. The Board found that if Mercy could establish that it was, in fact, an interstate air carrier, it would be able to establish the benefit of the exemption. However, the decision appears to offer no guidance with respect to what Mercy would be entitled to charge. Presumably, Mercy's argument is that it can charge what it wants, but that is the same argument the surgery centers used to make prior to the surgical center Fee Schedule. Whatever is charged still must be reasonable, although we suspect that the lien claimant will make the pitch that its charge is to be considered reasonable until something is presented to rebut it. However, although the Fee Schedule certainly would not be binding, we cannot see why it could not be used as evidence of what would normally be reasonable.

VIII.

MISCELLANEOUS

(a) Abuses of process. Several significant sanction cases were recently decided. Quite frankly, it appears much of this can be avoided by the observance of several common sense guidelines (as suggested by both the commissioners and Judge Moran): essentially, be honest; don't mislead people, and don't play games with the system. Furthermore, if we practice and work in this area of law, we are expected to have a certain rudimentary knowledge about how things work. That appeared to be the underlying admonition in Torres v. AJS Sandblasting, 77 C.C.C. 1113 (2012) which sanctioned a lien claimant for showing up at trial without any evidence to support its case. As we suggested in our prior paper, while we have some doubt that this principle would be applied to an applicant, there is a strong suggestion that this principle could well be applied to employers/defendants reasoning that they are more sophisticated: in other words, contesting an applicant's claim at trial with no substantial evidence to support the contest might well expose the defendant to sanctions.

Moving down the line, we have Malinowski v. HSM Electronic Protection Services, 41 C.W.C.R. 121 (2013), which involves the issue of "rudimentary knowledge". Unhappy with respect to an order closing discovery and setting a matter for trial (we are not certain that defendant's unhappiness was unjustified, and we were somewhat uncomfortable by the apparent smugness of several of the panelists, including a judge, discussing the defendant's predicament), defendant filed a Petition for Reconsideration and/or Removal. That was a mistake. As the WCAB made clear, it is elementary that an order closing discovery and setting a matter for trial is not a final decision for any purpose whatsoever, so a petition for reconsideration is unjustified. The problem is that a petition for reconsideration deprives the lower court of jurisdiction, so the commissioner saw this as being "gamesmanship". Sanctions were ordered.

The problem with the approach chosen by defendant in this case is that it caused the Board to pretty much completely overlook whatever merit there may have been in defendant's argument with respect to the closing of discovery. Lesson 1. Don't play games with the Board.

The next several cases go beyond mere gamesmanship. Escamilla v. Workers' Compensation Appeals Board, 2013 Cal. Wrk. Comp. LEXIS 67 (2013) was a Court of Appeal decision upholding the Workers' Compensation Appeals Board's suspension of a workers' compensation hearing representative for repeated acts of misconduct. This case has a long history involving petitioner's parliamentary maneuvers attempting to avoid a hearing on the merits, pretty much challenging the authority of the Workers' Compensation Appeals Board to suspend him from practicing before it. He had been sanctioned for improper conduct in connection with his representation of lien claimants on multiple occasions, and because these sanctions apparently were having no effect on his conduct, the Board took steps to suspend him from practice. It was obvious from the history that petitioner had no remorse about what had been going on in his practice, and what was truly surprising was the suspension was for only 90 days.

Two related cases, United States Fire Insurance Company v. WCAB, 75 C.C.C. 547 and Ezra v. Workers' Compensation Appeals Board, 73 C.C.C. 391 (2008), involve the same attorney, acting in the one instance as a defense attorney, and in the other instance as an applicant's attorney. In one case, involving the denial of the attorney's discovery motion, he essentially called the workers' compensation judge corrupt in his Petition for Reconsideration. And in the second, when he was admonished by the Board to use some restraint in connection with his insulting of the other attorney, he wrote a letter to the commissioners advising them that they were imbeciles and/or crooked who should not be allowed to sit in judgment. Needless to say, none of this went over particularly well and sanctions were the result. Interestingly, the commissioners tell us that the attorney refused to pay, so he was thereafter hauled up in front of the State Bar, which suspended him from practice.

The lesson: do not abuse or insult the judge; in the end, they run the show.

The last case is an absolutely terrible case for defendants, and truly may well stand for the proposition that bad cases make bad law. The Romano Trust v. Kroger Company, 78 C.C.C. ____ (2013) involved an applicant who sustained admitted physical injuries, the treatment for which went completely bad, with resulting paralysis, urinary/fecal incontinence, renal failure, psychiatric and vision problems (the consequential consequences were related to a MRSA infection which he contracted during the course of an industrial surgery, and essentially resulted in the collapse of all of his body functions). For reasons which are unclear, applicant had terrible difficulty obtaining authorization for ongoing medical care. He turned to Medi-Cal for payment of his expenses, and a hearing was eventually held at which the defendant was ordered to provide care, but defendant did not comply. When applicant was hospitalized for the final time after his catheter bag was found filled with blood, defendant refused to authorize the hospitalization, and applicant died. Not good. The defendant was hit with eleven $10,000.00 penalties and was referred to the audit unit. The panelists discussing this case indicate that the case is being used as a catalyst to convince the Legislature that present penalties are simply not severe enough, and that the current low levels encourage claims administrators to abuse applicants as in the Romano case. That is not true, of course. Romano would appear to be a glaring exception to the manner in which business is usually done in workers' compensation, but, unfortunately, it is glaring. CAAA feels that the case will have far reaching consequences in terms of legislative action.

(b) MPNs. Valdez is still pending before the California Supreme Court. The commissioners advised that the Workers' Compensation Appeals Board has written the Supreme Court, suggesting that the Valdez issue (admissibility for reports generated outside of the MPN) has been addressed by the legislature by virtue of Labor Code § 4605, which provides that reports by an applicant's selected consulting or attending physicians should not be the sole basis of an award of compensation. Indeed, Labor Code § 4061(i) provides that a Declaration of Readiness to Proceed with respect to permanent

disability cannot be filed in connection with §4061 issues unless there has been a medical-legal evaluation by either a Panel QME or an AME.

A fairly recent panel decision, Charon v. Ralph's Grocery Company, ADJ3417200 (March 22, 2013) discusses the cases of Knight v. United Parcel Service, 71 C.C.C. 1424 (2006) and Babbitt v. Ow Jing, dba National Market, 72 C.C.C. 70 (2007) (regarding notice of the requirement that treatment be received through an MPN and with respect to transfer into the MPN), and noted that there is nothing in the MPN statutes which precludes a defendant from curing any defects in notice and issuing adequate notices, so as to require treatment within an MPN.

(c) Psychiatric Thresholds. County of Sacramento v. WCAB, 78 C.C.C. _____, (2013) provides that a claim for psychiatric injury is barred where a substantial cause of the injury (35% to 40%) is a personnel action pursuant to Labor Code § 3208.3(h), and the determination of what constitutes a personnel action is a legal and not a medical question. However, the important thing here is that even if 100% of the psychiatric injury has underlying industrial causes, if the 35% to 40% threshold with respect to lawful, non-discriminatory, good faith personnel actions is met, the claim for psychiatric injury is barred, even if the rest of the disability would otherwise be considered compensable.

(d) Temporary Disability. County of Alameda v. WCAB, 78 C.C.C. 81 (2013) involved a deputy sheriff who was industrially injured and became temporarily disabled. He received a full year of Labor Code § 4850 pay and thereafter went on temporary disability, which terminated after an additional year. His argument that the Labor Code §4850 pay should not count against the 104 week cap was rejected.

(e) Carve-Outs. We do not see many of these, but they are essentially a mandated alternative dispute resolution mechanism set forth in collective bargaining agreements, as authorized by Labor Code § 3201.5. More of the Trades are apparently investigating this, and there are some forms of limited legal representation for the applicant. Very restricted representation for the applicant is still found in connection with the collective bargaining agreements of the electricians, pipe fitters, and sheet metal workers, although all of the

programs provide an "ombudsman", the functions of which are similar to an information and assistance officer. Medical treatment is generally limited to specifically identified providers, and the initial proceedings, at least, are generally accomplished through a form of mediation (following mediation, all of the plans allow active participation by applicant's counsel).

(f) Same Sex Marriages. On June 25, 2013, the United States Supreme Court announced its decisions in the cases of Hollingsworth v. Perry (regarding California's Proposition 8) and United States v. Windsor (regarding the Federal Defense of Marriage Act). In Hollingsworth, the court held that, where the state of California refused to defend the Proposition, the Proposition's proponents had no standing to defend it, while at the same time deciding that the Defense of Marriage Act was unconstitutional. The apparent effect of both decisions was to legitimize same sex marriages.

During the legislative session, it was claimed that these cases would have a significant effect on workers' compensation death benefits. Quite frankly, we do not think so, with the limited exception of the total dependency presumption for a spouse set forth in Labor Code § 3501(b). The death benefit statutes (Labor Code §§ 3501 – 3503, defining dependency, and 4700, et seq. never really defined entitlement to benefits in terms of specific relationships, only with respect to the extent of dependency (with the exception of minor children). The only time a spouse is specifically mentioned is Labor Code § 3501(b), and that section provides that a spouse is conclusively presumed to be a total dependent upon the deceased employee when that spouse has earned $30,000.00 or less in the 12 months preceding death.

Thus, even in the absence of a legitimate marriage, if the partner in a same sex relationship was able to establish dependency, under the statutes, that person would be entitled to a death benefit. The only difference the legitimization of a same sex marriage is going to make would appear to be with respect to the total dependency presumption under Labor Code § 3501(b).

(g) Jurisdiction. In the context of professional athletes AB1309 is still bottled up in the legislature (this statute would restrict the ability of out-of-state athletes working on out-of-state teams from maintaining a cumulative trauma claim within the state of California). There have been several recent cases with respect to this very issue. Initially, there was Matthews v. Nashvill, 77 C.C.C. 711 (2012), involving a member of the Tennessee Titans who had signed a player contract agreeing that any workers' compensation claim he might have against the team would be adjudicated under Tennessee law. It was determined that this was a valid contract provision, and applicant was precluded from litigating his claim in California. A similar case involving Arizona (Mckinley) involved a contract with the same provision and the Board found that, while it had jurisdiction, the employee was bound by the choice of law clause in his contract.

The very recent case of Wesley Carol v. Cincinnati Bengals, etc. 78 C.C.C. ____ (2013), actually goes a step farther. Applicant was in the NFL for three years, two years with the New Orleans Saints, and one year with the Cincinnati Bengals. He never lived in the state of California and played a total of six games here, five with the Saints and one with the Bengals. He filed a cumulative trauma claim in California, and received an award, but only the Bengals filed for reconsideration. In this case, the WCAB decided that applicant was only a temporary employee within the state, and that the Board thus had no jurisdiction. The lament from the panelists was that Ohio had a one year statute of limitations, which applicant had apparently blown, and thus had no recourse.

The simple answer is that AB1309 should not even be necessary, but for a somewhat twisted system which has elected to adjudicate a type of industrial injury, California's contribution to which is entirely speculative. We are not talking about an individual who suffers a specific injury (a professional athlete who goes down on the field as a result of an incident, and suffers injury and a disability as a result), a California resident (in which the state would legitimately have an interest with respect to well being), or a California employer. Instead, we are talking about cumulative trauma injuries occurring over prolonged periods of time during employment with out-of-state

employers by out-of-state residents, who have incidental contacts with the state of California by way of participation in an occasional professional sporting event (and perhaps not even participation; perhaps the person sat on the bench). In Carol's case, his average presence in the state of California was two days per year. Common sense would seem to indicate that such an incidental contact should be insufficient to cause California to exercise jurisdiction or apply its choice of law. In short, the state of California does not have a significant interest in the outcome.

IX.

CONCLUSION

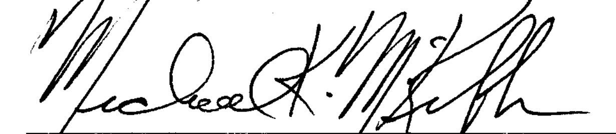
Interestingly, the atmosphere at this convention appears to be one of grudging acceptance of what CAAA has to work with. The primary area of concern appears to be independent medical review which becomes effective for all cases as of July 1, 2013. There is a distrust of this system, although this distrust appears to be based upon the unknown more than anything else. From what we are hearing, it does appear that an applicant's attorney is going to be taking much harder looks at the procedural adequacy of utilization reviews, and the members have been encouraged to file expedited hearing requests to challenge utilization reviews in every case where it is felt there have been procedural inadequacies. At the same time, the panelists are also encouraging simultaneous filings of independent medical reviews.

There is a practical problem, and that relates to the expense. Each review is going to be in excess of $500.00. In questionable cases, this may well effect claims decisions as to whether or not to stand hard behind the utilization review.

Our firm will be more than happy to answer any questions you might have in connection with the topics presented in this paper, and are more than willing to discuss any issues you may have with respect to workers' compensation, whether related to specific general issues. We are available for continuing education sessions, and encourage you to contact us for such events.

Very truly yours,

BENTHALE, MCKIBBIN & MCKNIGHT



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