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THE DEFENSE PERSPECTIVE

AND OBSERVATIONS OF THE

CALIFORNIA APPLICANTS'

ATTORNEYS ASSOCIATION

SUMMER CONVENTION, 2003

MONTEREY, CALIFORNIA

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2003 SUMMER CONVENTION OF THE CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION (June 19, 2003 - June 22, 2003)

TO OUR CLIENTS:

We did have the opportunity to attend the 2003 Summer Convention of the California Applicants' Attorneys Association in Monterey, California, held between June 19, and 22, 2003. The atmosphere of the convention was in stark contrast to the Summer convention of a year ago, when the convention delegates were almost giddy with delight over the past AB 749. At that time, the delegates advised they did not wish to extensively discuss the substantial provisions of a new legislation, since there was still time for legislative corrective action, but promise that, come 2003, methods of maximizing monetary recovery under the new rates legislation would be discussed in depth.

That did not happen at the 2003 Winter convention, as the state's deepening budget crisis made the continuing viability of the substantive provisions of AB 749 and issue. Thus, in terms of statutory and regulatory amendments, the primary focus of the Winter, 2003 convention was on regulatory changes (and those were substantial). The "stick it to the carriers" bravado of past conventions was missing at the Summer, 2003 convention as well. In fact, the pervading atmosphere was concern and worry for the continued survival of a system in which we all, quite frankly, make our living. While some of the more strident count not resist pointing fingers of blame (i.e., it was all the fault of the carriers due to bad investments, cut-throat competition following deregulation,

etc.), most people seem to realize that blame was not going to be solving any problems.

Perhaps the most significant statement of the convention was made by Michael Mattoch, the chief consultant to the assembly insurance committee, who essentially said that the carriers took a bath in the economic market, but that we were all going to let the carriers recoup their losses, "... because we need them." Yes, we do, all of us.

With that in mind, we turn to the topic of utmost concern, that being the area of pending legislation.

I.

PENDING LEGISLATION

As we reported in connection with the Winter, 2003 convention, the democratic faction of the legislature was complaining that the republicans were threatening to hold the state budget hostage in connection with, among other things, workers' compensation reform. The delegates indicate that various republican interests have 40 or 50 legislative proposals floating around, most of which apparently involve a roll back of the benefit increases which were an integral part of AB 749, or which possibly envision a complete scrapping of the present workers' compensation system altogether. This latter type of proposal is apparently one of the proposals which is being shopped around by the California Insurance Commissioner John Garamendi (described by the delegate as essentially a "kill all the lawyers" type of proposal). Shortly before the convention, we did receive a position paper from the Commissioner's office entitled "The Garamendi Plan for Workers' Compensation Reform", which appears to have been prepared on June 6, 2003. For your information, a copy of the Plan is included as an addendum at the rear of this report.

This particular plan does not appear to be consistent with the sweeping revision (or scrapping, as the case may be) of the system which the convention delegates indicated that Garamendi was proposing. In fact, the Plan basically is a cost containment approach within the present system, which would not appear to have a terribly significant effect on present procedure in the processing of claims.

Actually, The Garamendi Plan to a large extent, mirrors the primary concern of the delegate speakers (Senators Burton, Alarcón, and Murray), who certainly suggested that the biggest focus of the democrats with respect to workers' compensation reform was medical cost containment (and, interestingly enough, Senator Burton's comments indicated no respect for the surgery centers at all). In essence, the democratic back proposals (and it is the convention delegates belief that these proposals are the ones with the best chance for succeeding, although some additional compromise and fine tuning is obviously going to be necessary) are Senate Bills 191, 228, and 229, and Assembly Bill 226 (which is essentially the assembly version of Senate Bill 228). From a claims standpoint, Assembly Bill 226 and Senate Bill 228 are the most significant, since these are the bills which relate to the regulation of medical costs. Essentially, the legislature has made a determination that it is going to step in to the area of cost regulation (something traditionlly left to the rulemakers), since, despite legislative authority to develop fee schedules, budget and other constraints have prevented this (it was noted that it took 5 years to come up with an inpatient hospital fee schedule after that had been authorized). The primary focus of the legislature is surgery centers, chiropractic care, and physical therapy (and, inferentially, prescription drugs), and the core proposal being considered in the system which pays medical providers 120% of which is allowed by medical care (something that has the medical providers literally screaming. The speakers did indicate that there is probably going

to be room for some adjustment here, but the message is that some of these changes are going to be draconian.

Also as noted by Garamendi, the legislature is also considering a utilization schedule, i.e., medical treatment according to a criteria of what is effective. In other words, the physical therapy or chiropractic care has been ongoing for a period of time without significant effect, that's enough. Our caseloads are loaded with files where medical care is being administered by free-choice doctors who have been prescribing physical therapy/chiropractic care, or other types of care for years without any appreciable effect, except for an ever-growing bill.

The other proposed bills essentially relate to a freezing of premium rates for a period of years the employer has a "good injury record" (Senate Bill 229), as well as involving some degree of regulation of the insurance industry itself (Senate Bill 191). Having some relation to the healthcare issue is Senate Bill 2, which will require all employers to provide group health insurance, or paid to the State a certain amount of money in lieu of providing that healthcare insurance (presumably in anticipation of the State providing some sort of health care to those persons whose employers do not otherwise provide it). We do note one aspect of the Garamendi proposal is to create more "carve-outs" similar to the limited ones presently existing in certain portions of the construction industry, which basically create alternative dispute resolution systems outside of the Workers' Compensation Appeals Board (it is, perhaps, this aspect of the Garamendi proposal which is disliked by the Association, in which perhaps colors its view of the entire proposal, which actually seems to make some degree of sense). One of Garamendi's most-notable proposals is with respect to what he terms a "irrational penalty structure", in which he complains that penalties, in many cases have no reasonable relationship to the alleged wrong, a concept we can certainly agree with).

At least at this time, what is overshadowing and influencing everything is the State budget and, at least at this time, that appears to be what is driving much of this legislation. The legislators who appeared at the convention made it clear to the delegates that some compromise in the area of workers' compensation is going to be necessary. The remarks suggested that the most significant legislation is likely to be in the area of cost containment, although it is really difficult to tell at this point exactly what the final product will be. Not only are the democratic and republican members of the assembly and senate involved in shaping this change with their ideas, and as we have seen Insurance Commissioner Garamendi is pitching a plan, and we understand Governor Davis is pressing ideas as well. We suspect that, with the need for adopting a budget becoming increasingly critical, these changes should take final form fairly quickly. Stay tuned.

II.

MEDICAL TREATMENT AND CONTROL

Virtually all of the litigates with which we now view are, from a medical standpoint, "presumption" cases, that is, cases where the date of injury is between January 1, 1994 and December 31, 2002, in connection with which application of a presumption of correctness in favor of the treating physician is possible under Labor Code §4062.9. The statute applies when one side or the other obtains a comprehensive medical evaluation pursuant to Labor Code §4061 and/or §4062, and the other side elects to rely upon the opinions of the treating doctor, in which case the treating doctors' opinions are accorded a presumption of correctness. The statute provides that the presumption can be rebutted by a preponderance of medical opinion indicating a different level of impairment (what this means was explained in Minniear v. Mt. San Antonio Community College District, 61 CCC 1055 (1996), essentially indicating that the contrary medical opinion must establish

that there is a different level of impairment, the treating physician's evaluation is no longer germane, or the QME evaluation is more thorough than that of the treater in light of the regulations). Lip service is paid to the proposition that an applicant's testimony, even when coupled with a contrary QME opinion, is insufficient to rebut the presumption, but the reality is that, at least where the applicant is attempting to rebut the presumption, this is not really true. Keulen v. WCAB, 63 CCC 1125 (1998), where it was stated that applicant's "credible testimony" and allegedly uncontradicted medical evidence was enough. We do note that applicant's testimony can be used as justification that the treating physician's opinion was based upon incorrect facts, which will serve to defeat the presumption. Teledyne Ryan Aero v. WCAB (Ausen), 62 CCC 832 (1997). The bottom line is that experience over the years has demonstrated it is much easier for an applicant to defeat the presumption of correctness than it is for a defendant.

There are several ground rules for application of the presumption: it applies only in an admitted injury case (in other words, there is no presumption that the treating physician's opinion on compensability is correct). Vidal v. WCAB, 62 CCC 723 (1997). Furthermore, it should be fairly obvious from Labor Code §4062.9 itself, the presumption would not apply if both parties obtained qualified medical examiners (although, as will be seen below, a recent Court of Appeals case may lend itself to a disturbing interpretation that this might not necessarily be the case where an applicant decides to use his own QME as a treater). The presumption also does not apply if applicant has no primary treating physician when the disability issue arises (i.e., probably in a situation where applicant has not obtained medical care for a significant period of time). Winters v. WCAB, 63 CCC 1101 (1998). It also does not apply where the treating physician has not complied with the requirements of Labor Code §4061.5 and Rule 975 (reporting requirements), CNA Insurance

Company v. WCAB (Ortiz), 63 CCC 206 (1998). Finally, the presumption does not apply if the treating physician's report does not rise to the level of substantial evidence. Hernandez v. WCAB, 66 CCC 1369 (2001) (the objecting findings did not support the work restrictions, where applicant's subjective complaints were found not credible).

From a defense standpoint, probably the most significant case which affected the application of the Labor Code §4062.9 presumption (although it did not directly involve the presumption itself) was Tenet/Centinela Hospital Medical Center v. WCAB, 65 CCC 477 (2000). Essentially, Tenet interpreted the provisions of Rule 9785(b) (applicant shall have no more than one primary treating physician, and if the primary treating physician discharges applicant without a need for continuing medical care, then that physician shall remain the primary treating physician until any dispute with respect to a need for medical care is resolved) as requiring compliance with the dispute resolution provisions of Labor Code §4061 and/or §4062 (essentially, the obtaining of a comprehensive medical report, and as that term is used in Labor Code §4062.9). This is still good law (STS v. WCAB {Antico}, 65 CCC 1220), but we have always considered Tenet to be more of a temporary stop gap which an applicant will eventually be able to overcome (except possibly in the case where an applicant is beyond the 5-year statute for reopening), and some fairly recent cases have certainly made some inroads. A few cases (one involving an unrepresented applicant, and the second involving a represented applicant) have certainly softened the effective Tenet, and have suggested what clearly appear to be incorrect interpretations of Labor Code §4062.9, regarding application of the presumption of correctness. The first is Gee (Shelly) v. WCAB, 67 CCC 236 (2002) where an unrepresented applicant, after being discharged with out a need for continuing medical care by the treating physician, requested and received an evaluation by a qualified medical examiner, who felt

that applicant had a continuing need for treatment. The Court of Appeal held that, under the circumstances, applicant had satisfied the obligation to comply with Labor Code §4061 and/or §4062, and was thus entitled to choose a qualified medical examiner as the new treating physician. In Gaytan v. WCAB, 68 CCC ______ (May 28, 2003), a case which the Association feels is the most significant to have come along in a the last year, we basically have the same set of facts except, after discharge by the treating physician, applicant obtains an attorney who objects to the treating physician's report and offers an Agreed Medical Examiner pursuant to Labor Code §4061 and/or §4062. When there was no reply, applicant was sent to a qualified medical examiner (who we assume, did a much more thorough evaluation and, as the result of an MRI did discover something which certainly was not diagnosed by the treating physician), and the QME found applicant had a continuing need for medical treatment and was temporarily disabled. Applicant thereafter chose a qualified medical examiner as the primary treating physician, and it was off to the races.

Consistent with the Gee case, the Court of Appeal found this to be permissible, they reasoned it would be unfair to force an applicant to wait for critical medical treatment pending an adjudication of the differing medical opinions by the Board, so applicant was entitled to self-procure the treatment, if necessary. At that point, reasonableness and necessity of the self-procured treatment must still be adjudicated by the Board, with the presumption of correctness going to the original treating physician. So far, so good.

Where Gaytan and Gee are most disturbing, however, is their suggestion that where the Board finds that the presumption of correctness in favor of the original treating physician has been rebutted, and that applicant was thus legitimately entitled to change physicians to his own QME, that new primary treating physician would be entitled to the presumption of correctness under Labor

Code §4062.9. This appears to be completely contrary to the terms of the statute for a couple of reasons: First, the presumption would not apply in any case unless defendant obtained a qualified medical examination report of its own (although, this issue is academic if the only opinion to be considered is that of the treating doctor). More importantly, however, is that applicant has gotten to this second primary treating physician by obtaining the comprehensive medical evaluation described in Labor Code §4062.9 and thus, under any circumstances, would not be able to claim the benefit of the presumption. We suspect that the rationale for the implication is that the original selection of a QME did not involve the issue of permanent disability (rather, medical treatment), so that a challenge of the new primary treating physician on the issue of permanent disability is a new challenge within the meaning of the statute, with respect to which applicant's prior selection of a QME on the limited issue of medical care would have no bearing. Certainly, however, where applicant had been previously discharged without disability and need for medical care, it would appear that the initial objections certainly involved issues of permanent disability.

Fortunately, after three or four or five years, we really will not have to concern ourselves with this very much anymore. As we are all probably aware, as of January 1, 2003, Labor Code §4062.9 was amended to provide the treating physician presumption will only apply to an employee's personal treating physician or chiropractor who is pre-designated prior to the date of injury pursuant to Labor Code §4600 (the personal treating physician or chiropractor is one who must have previously directed the medical treatment of applicant, and who retains applicant's medical records, including his or her medical history. Labor Code §4601). The predesignation to the employer must be in writing (Rule 9780.1), but applicant attorneys are taking notice of the employer's obligation that post-notice of an applicant's workers' compensation rights, including the right to pre-designate

a personal physician (Labor Code §3550); and the obligation to give all new employees written notice of their right to designate a personal physician (Labor Code §3551; Rule 9881). Given the new status of the pre-designated, personal treating physician, the consequences of the employer failing to give these notices is not quite clear {although there seems to be some consensus that the failure would cause the employer to lose the first 30 days of medical control pursuant to Labor Code §3550(e)}. We suspect that, at some point, we will see an applicant claiming that his personal treating physician is entitled to a presumption of correctness based upon a failure to give the required notices.

As a practical matter, in most situations, the situation will be as it was prior to 1990: even without the presumption, a reasonable treating doctor will still have an advantage, and since he has the opportunity for multiple observations of the applicant, and the opportunity to follow his medical course, as opposed to a qualified medical examiner, who generally sees the applicant on only one, limited occasion.

In connection with qualified medical examinations, applicants do have an additional advantage at this point, pursuant to Labor Code §4061(e): they get a second bite of the apple if they become represented after utilizing a panel qualified medical examiner, and are entitled after representation to obtain another qualified medical examination (assuming they did not like the first one). There is some concern as to what, exactly, constitutes representation. We have run across more than a few cases in which supposedly unrepresented applicant are receiving advice from attorneys in connection with the panel QME process (relating first with respect to what doctors to choose, the information an applicant should bring to the attention of the doctor during the course of an evaluation, and how to deal with the results of the evaluation, even perhaps, to the extent of

receiving referrals for medical treatment. Everything is a matter of degree, of course, but it is clear that some applicants are receiving the benefits of representation long before any disclosure statement is filed, and this may eventually become an issue.

A timely objection to the report of the primary treating physician is still required, although we think this requirement is in forth very rarely against the applicant (if at all). Labor Code §4062 does contain time limits for objecting (20-30 days, depending upon whether an applicant is represented), while Labor Code §4061 does not contain such limits, but by judicial decree has been deemed to imply that there is only a reasonable time to object. County of Santa Barbara v. WCAB (Finch), 64 CCC 907; Owens Illinois v. WCAB (Araiza), 66 CCC 417; Ordorica v. WCAB, 66 CCC 333.

An issue which has become more critical, especially as far as the defense is concerned, is the time it is taking to get a quality qualified medical examination report. Applicant attorneys are complaining (perhaps with some justification) that appointments with defense qualified medical examiners are being set months in advance, with additional months going by from the time the examination is conducted, until the time the report is received. It appears there may be some movement to at least correlate the regulations relating to evaluations by panel medical evaluators, qualified medical examiners (Rule 33 provides that a qualified medical examination appointment must be provided within 60 days of the request, and Rule 38 provides that he has 30 days in which to complete the report. We have argued that, since applicant had his choice of doctor, we should have our choice of ours, but this becomes difficult to justify when applicant's doctor sees the applicant within days or weeks of the time the appointment is made (there are ads in the CAAA

convention syllabus by physicians who are advertising a 2-day turnaround), and our defense evaluator is indicating they cannot see the applicant for three to four months.

Applicant attorneys point out that Rule 33(e) provides that if a doctor is unavailable for a qualified medical evaluation appointment for more than 90 days, that alone is a ground for denying reappointment to the qualified medical examination panel.

A terrible trap represented by a completely idiotic decision is illustrated in LAUSD v. WCAB (Perry), 66 CCC 533. This case stands for the rather moronic proposition that the objection to a treating physician's opinion regarding Labor Code §4062 issues before the treating physician has issued his permanent disability findings, does not preserve the defendant's right to obtain a QME report addressing permanent disability. The absurdity of this is apparent. Many times, we object to the treating physician's ongoing, ineffectual, and seemingly endless treatment, because of our belief that the medical provider is simply churning the account, and then applicant has probably been permanent & stationary for a long time, an assumption which is often confirmed by the defense qualified medical examiner, who renders opinions with respect to applicant's disability status (i.e., permanent & stationary, and presumably when that status occurred), factors of permanent disability, and QIW status. What Perry says is that this report is inadmissible on the issue on permanent disability. In essence, the defendant is required to object to the treating physician's final report and then, presumably, must obtain another evaluation.

III.

CIGA

Like it or not, CIGA has become critically important in the world of California workers' compensation. Roughly 25% of all California claims are now being administered by CIGA, incredibly, almost 60% of all claims are administered either by CIGA or State Compensation Insurance Fund, with traditional insurance accounting for only about 15% of the claims and PPA's, and joint powers, are self-insureds counting for the rest.

CIGA's relatively rapid rise to prominence may well spell the end of an applicant's ability to freely elect against a target defendant and a multiple party cumulative trauma case (as is permitted under Labor Code §5500.5). Even if the defendant initially elected against his solvent (the carrier or a self-insured) should the carrier become insolvent at a later stage in the proceeding, applicant's case becomes unraveled, and he needs to start all over again. For this reason, we think we are going to think much less by way of objection, and we think the norm is going to the applicant's attorney holding all defendants in the case as long as possible.

The truly significant issue in all multi-party cases involving CIGA relates to the definition of a covered claim, coupled with the principle that CIGA is considered an insurer of last resort (although legally, it is not an insurance company). Because of this status, there are a number of exclusions from what constitutes a "covered claim" as to CIGA, and the most litigious of these exclusions is contained Insurance Code §1063.1(c)(9), which provides that there is no covered claim if other insurance covering the losses available to either the insured or the claimant.

Gomez v. Casa Sandoval, 68 CCC ______ (May 27, 2003) (en banc decision) attempts to clarify exactly when this provisions comes in to play. It certainly comes in to play in the case of a

single cumulative trauma injury involving both CIGA and at least one other solvent carrier, and under these circumstances CIGA will be relieved of any liability (assuming it has been determined that the period of injurious exposure did not occur solely within the coverage afforded by the carrier now being administered by CIGA. The situation is somewhat different, if the insolvent carrier being administered by CIGA became insolvent following the issuance of an award, approval of a settlement, or issuance of a decision fixing that carrier's rights and liabilities (again, assuming a multi-carrier cumulative trauma case). Under those circumstances, the liability apportioned to the now insolvent carrier is binding on that carrier, and thus binding on CIGA.

In the case of successive injury claims (essentially a series of specific injuries) which are within the coverage of CIGA and other solvent carriers, an apportionment of liability must be made setting forth the specific percentages of liability for all carriers, so as to establish CIGA's liability for any non-solvent carrier (in other words, to an extent, it really is no different than CIGA's liability would be in the case of any specific injury; the result is actually an apportionment issue). Electing against CIGA is out, and if the insolvent carrier for which CIGA administers was responsible for administering an award, absent extraordinary circumstances, CIGA will be relieved of that obligation (again, in the case of a multi-party cumulative trauma where there are other solvent carriers).

This case, of course, involves an interpretation of rather substantive law (i.e., the definition of a covered claim under Insurance Code 1063.1), and it is unclear whether the case will stop here. We are not sure that CIGA is going to be happy about sharing liability with anyone, whether that be in the context of apportioned liability in a case where a carrier's insolvency post-dates the issuance of an award in a cumulative trauma case, or even shared liability for non-apportionable benefits such

as medical expense and temporary disability in light of §1063.1 (c)(5)'s exclusion of contribution as a covered claim.

A corollary to this case is Lee v. Miracle Ford, 68 CCC 213 (2003), to the effect that an applicant may not elect against the California Insurance Guarantee Association where a solvent insurance company with coverage for a part of the cumulative trauma exists (although the Board also felt that, until there was a determination with respect to the actual date of injurious exposure, CIGA should not be dismissed).

The litigation over what constitutes a covered claim is also served to expand the definition of what constitutes other insurance. In Denny's, Inc. v. WCAB (Bachman), 68 CCC 1 (2003), applicant alleged a repetitive trauma injury during which the employer was self-insured for two months, with the balance of the period of injurious exposure being under the coverage of an insolvent carrier (HIH America), now being administered by CIGA. CIGA claimed that the self-insured employer was the legal equivalent of "other insurance" under Insurance Code §1063.1, and the Court of Appeal agreed, the court finding that self-insurance was the legal equivalent of insurance.

Significantly more complex issues represented in the case of Miceli v. Jacuzzi, Inc. (Remedy Temp, Inc.) 68 CCC 434 (2003), involving a 540 case consolidation coupled with a stay order. The issue here involved a legal status of a general/special employment relationship. The general employer, Remedy Temp, a temporary employment agency, was insured by reliance, which became insolvent and administered by CIGA. The special employer, Jacuzzi (at least in the test case) had valid workers' compensation insurance, although applicant was not on Jacuzzi's payroll. CIGA claimed that the special employer's insurance was "other insurance" within the meaning of the

Insurance Code §1063.1 exclusion, and that it should thus be exonerated from liability. The most serious opposition in this case came from Reliance's own insured, Remedy Temp, the general employer, which, among other things, made a policy argument that a finding in CIGA's favor would have the effect of destroying the temporary employment business because of its inability to live up to its contracts (the contracts provided that remedy temp would provide all benefits for the employees provided by it, including workers' compensation insureds).

The policy argument obviously went nowhere, since CIGA was not Remedy Temp's insurer, was a creature of statute, and had no connection to Remedy Temp's contacts in any event. For workers' compensation purposes, general and special employers are jointly and separately liable (Miller v. Long Beach Oil, 24 CCC 77) although Insurance Code §11663 provided that the general employer would have full liability, unless the employee was on the special employer's payroll at the time of injury. This Insurance Code section was held not to protect the special employer, however, since it had only applied to insurers and CIGA is not an insurer. Labor Code §3602(b) (permitting a special employer to be covered as an alternate employer on the general employer's policy) was found not to apply either, since the purpose of this section was to insulate a special employer from criminal liability for failure to obtain workers' compensation coverage (and in this case, the special employer did have workers' compensation coverage). In looking to Jacuzzi's policy, it was also noted that there was no specific exclusion with respect to temporary employees. Ergo, the Board found that the special employer's workers' compensation insurance constituted other insurance within the meaning of the exclusionary section, and that CIGA was relieved of liability.

We have not heard the last of this case yet, since a Petition for Writ of Review has been filed with the Court of Appeal, and the stay remains in effect.

The result of all of this is that convention delegates are being urged to name both the general and special employers and their respective carriers, and all cases involving general and special employment we suppose this is going to make for some interesting law and motion. This is also causing applicant attorneys (as well as the Boards) to become more insistent with respect to disclosure. The true identities of the various parties (particularly, who is responsible for making appropriate payments. These disclosure requirements are incorporated in Cold Iron v. Compuware, 67 CCC 289, requiring disclosure with respect to insurance coverage, policy limits, retention limits, and deductibles, when requested.

IV.

EARNING ISSUES AND RATES

Earning issues are certainly going to become more prominent in light of the dramatically increased rates as of January 1, 2003. As we all know, the primary method of determining an applicant's indemnity rate is by obtaining a valid wage statement, and going from there. The panelists have suggested that the wage statement might not be enough:

1. Tip Income: As a practical matter, most judges we have run across seem to take the position that if an applicant has not reported his or her tips for taxation purposes, then claimed unreported income is not going to be used for the purpose of calculating an average weekly wage. Unfortunately, this is not a uniform approach, and it has been suggested that applicant attorneys consider the use of an "earnings expert", who would presumably estimate tip income based upon gross receipts (although we note that some restaurants actually do this regardless of what their servers report, although these estimates are always reported on the W-2 form).

2. Earning Capacity or Potential: This has always been a potential issue, but is likely to become a more important one. The determination is generally easy enough (although something of an irritant) if a class of employees to which applicant belongs either is contractually entitled to, or, better yet, actually receives a salary increase which applicant would have received, but for the injury. Under the circumstances, it is pretty clear that applicant is entitled to an increased rate based upon that increase of salary.

The issue becomes much trickier when this kind of certainty does not exist, and applicant claims they were career minded with respect to the company, and on a promotional track which would have given them a reasonable certainty of increased wages, or that the employment at which the injury took place was nothing more than a weigh station on the way to what was a reasonably certain, lucrative career (the latter contention most frequently being encountered in the case of the student who is injured while engaged in part-time employment. In Grossmont Hospital v. WCAB, 69 Cal. Rptr. 2d 842, it was held that applicant's compensation rate must be determined as of the date of injury, taking in to consideration also perspective earnings, including raises.

3. Seasonal Piecework and Temporary Employment: Earnings histories are going to become particularly important with respect to these types of cases. From our standpoint, we are happy with the Board's current preference to simply take applicant's earnings for the entire year, and divide it by 52, for the purpose of determining a benefit rate. Convention delegates are talking about going back two or three years although, obviously, this is only going to be a benefit to them if those prior years showed earnings different and greater than in the current year.

4. Concurrent employment: This has always been an issue, but may become more important at this point because of the increased rates. Essentially, the average weekly wage is determined by

multiplying the number of hours worked in the concurrent employment by the hourly wage received in the employment at which applicant was injured, and adding the result to applicant's wage with the primary employer.

5. Perks: Applicant attorneys are going to be taking a closer look at employment perks, meals, entertainment, use of a vehicle, etc., essentially non-taxable types of items and benefits, for the purpose of determining an average weekly wage.

In connection with rates, it should be recalled that, in a case where temporary disability is disputed, that applicant eventually establishes an entitlement, the proper temporary disability rate is that which exists at the time of the issuance of the award (Hofmeister v. WCAB, 49 CCC 438). Furthermore, when there are two injuries and the Wilkinson doctrine applies (Wilkinson v. WCAB, 42 CCC 406, which very basically is to the effect that the permanent residuals of both injuries are rated as a single disability), the higher disability rate applicable to the latter injury applies to both injuries. (Fremont v. WCAB {McMullin}, 256 Cal. Rptr. 413).

Finally, in the area of public safety employment, there is the case of Fenn v. WCAB, ___ CCC ____ (2003) involving the calculation of applicant's pay rate pursuant to Labor Code §4850 (essentially providing the public safety employee receives one year salary for industrial temporary disability during that period of time). Applicant attorneys are up in arms about this case, complaining that applicant is being economically punished for being disabled, but what really appears to have happened was that applicant was apparently manipulating his schedule in such a way that he was receiving about nine hours of overtime per pay cycle. The court's position appears to be that this was an artificial manipulation, and that applicant was not really working for the money (overtime pay was designed to provide for hardship defined as excessive hours actually worked, and

applicant was really not meeting this definition), so it was determined that he was not entitled to include these hours in connection with the calculation of his Labor Code §4850 pay.

V.

DOMESTIC, HOUSEHOLD, AND PERSONAL EMPLOYMENT

After all these years, there is still litigation with respect to who is actually an employee. Labor Code §3351 generally defines an employee as "every person in the service of an employer". Specifically included are persons "employed by the owner or occupant of a residential dwelling whose duties are incident to the ownership, maintenance, or use of the dwelling, including the care and supervision of children, or whose duties are personal and not in the course of trade, business, profession, or occupation of the owner or occupant."

Labor Code §3352 excludes from this an inclusion any person who is employed by his or her parent, spouse, or child, or any person who had been employed by the employer to be held liable for less than 52 hours for the 90 calendar days immediately preceding the injury, or who earned less than $100.00 from the employer during that 90-day period.

With respect to this latter exclusion, the residential employee must meet both the earnings and hour requirements (not either or). Stewart v. WCAB, 50 CCC 524 (1985). It is noted though that, a person so excluded from workers' compensation is able to sue the employer in a civil arena (although fault would have to be established). Dreyer v. WCAB, 55 CCC 22 (1990). There is an exemption to the hourly requirement in favor of part-time gardeners under Labor Code §3715(b), in which the hourly minimum is reduced to 44.

The intent of the parties can affect how these statutes work. Thus, if there is a contract of employment (or, we assume, any type of agreement) which contemplates in excess of 52 hours of

work and the requisite 90-day period, then the applicant would appear to be considered an employee. Fichera and Allstate Insurance Company v. WCAB (May) 46 CCC 26 (1981); Wagner v. WCAB, 59 CCC 576 1993) (the employer testified that, but for the injury, applicant would have worked in excess of 52 hours). The requirements of the statute can also be satisfied if the combined hours at two different jobs for the same employer meet the statutory minimum. Ward v. WCAB (Gonzales) 62 CCC 403 (1997).

What is also important is what is considered to actually be work which is incidental to the ownership, maintenance, or use of the dwelling. Thus, it has been held that a caregiver is not subject to the exclusionary statutes, Galdamez v. State Farm Insurance Company, 27 CWCR 19 (1998) (has a live-in caregiver, the Board found that applicant was covered employee under Labor Code §3715(b), as either a household domestic, or a casual employee), although she certainly appears to have been performing duties which were "personal" within the meaning of Labor Code §3351); Atlas Insurance Company v. WCAB (Whitely), 50 CCC 587 (1985) (actually, this seems to be even closer than Galdamez, since this caregiver was not a "live-in"). Types of work not falling within the Labor Code §3351(d) definition included work on a structure, not qualifying as a dwelling (a garage, although this is a stretch), Allstate Insurance Company v. WCAB, 51 CCC 493 (1986); providing security services (Traub v. WCAB, 53 CCC 337 (1988); or the construction of a residence not yet occupied {Scott v. WCAB, 46 CCC 1008 (1981)}.

Related to this is the Labor Code §2750.5 presumption that a worker is an employee if the worker is performing services for which a license is required under the Business and Professions Code, and the worker does not have such a license (essentially, the unlicenced contractor). The basic rules as set forth in State Compensation Insurance Fund v. WCAB (Meier), 50 CCC 562, where the

unlicenced contractor was injured, and the court held that the unlicenced contractor was the homeowner's employee. A non-exception to this rule involves the interplay of Labor Code §3352(h) (the wages and hours limitation) which courts have held is a more specific statute than Labor Code §2750.5. Thus, in Dreyer v. WCAB, 55 CCC 22 (1990), applicant was hired by an unlicenced contractor, who in turn had been hired by the homeowner, but it was held that applicant was an excluded employee because he did not earn a minimum of $100.00 and did not work a minimum of 52 hours in the 90 days prior to his injury (while applicant was entitled to seek redress in the civil courts if he was able to prove fault).

The most recent manifestation of this is found in Cedillo v. WCAB (Rodriguez), 68 CCC 140 (2003), again standing for the proposition that an injured worker, hired by an unlicenced contractor, is not entitled to workers' compensation benefits if that worker has not worked at least 52 hours during a specific 90-day period, finding that Labor Code §3352(h) was more specific.

VI.

CONTINUING JURISDICTION AND THE PETITION TO REOPEN

The Petition to Reopen and, in connection with this, the Board's continuing jurisdiction over matters, received some attention. The Board's continuing jurisdiction is essentially spelled out in three statutes. Labor Code §5410 gives the applicant the right to institute proceedings for the collection of compensation within five years after the date of injury based upon new and further disability. Labor Code §5803 provides that the Appeals Board has continuing jurisdiction over all of its orders, decisions, and awards. Labor Code §5804 provides that no award of compensation shall be rescinded altered, or amended after five years from the date of injury, except upon a Petition by a party in interest filed within such five years, and any counter petition seeking other relief filed

by the adverse party within 30 days of the filing of the original petition. In essence, Labor Code §5410 confers the right to seek relief on the parties, and Labor Code §5803 and §5804 establish the jurisdiction and procedure to grant that relief.

From the standpoint of the petitioning party (and in almost all cases it is the applicant; in the entire convention, no one had specific recall of a Petition to Reduce filed by a defendant ever being granted, although the possibility was conceded in a circumstance where a defendant was able to obtain very good film of an applicant performing activities which would clearly appear to be precluded by his disability), the critical factor is that the Petition to Reopen must be filed within five years of the date of injury (a specific requirement of the statute). However, the technical rules of pleading to no apply {Beaida v. WCAB, 32 CCC 345 (1960)} and skeletal petitions are appropriate based upon the proposition that due process requires that the parties be given an opportunity to develop the record. Bland v. WCAB, 3 Cal. App. 3d 324 (1970); Blanchard v. WCAB, 40 CCC 784 (1975); Liberty Mutual Insurance Company v. WCAB (Aprahamian), 45 CCC 866 (1980).

This, of course, leaves for some rather interesting issues, particularly where a new type of disability (i.e., a psychiatric disability arising out of an orthopedic condition) develops after the expiration of the five-year period, but during the pendency of a timely-filed Petition to Reopen. Applicant attorneys naturally take the position that this additional, albeit different disability must be taken in to consideration in connection with an amended award of increased disability and, as a practical matter, this appears to be the position of the Board (otherwise, why else would the Board allow a skeletal petition). The basic proposition appears to be than an applicant is entitled to proceed with a claim of additional disability which actually occurs beyond the five years, so long as the Petition to Reopen is pending. Nicky Blair's Restaurant v. WCAB (Macias), 45 CCC 876 (1980)

(this case is regarded as one of the leading cases in the field of what constitutes good cause for reopening). Interestingly, the convention delegates suggest that one fairly obvious issue arising in this circumstance has never really been addressed on an appellate level: where a timely Petition to Reopen is filed, and where applicant subsequently becomes temporarily disabled after the expiration of the five-year period, is applicant entitled to temporary disability indemnity. From a defendant's standpoint, we have always taken the position that applicant is not entitled, since the temporary disability is new disability which occurs beyond the expiration of the five-year statute, and certainly was not in existence at the time the Petition to Reopen was filed. As might be expected, applicant attorneys claim that temporary disability would be payable, based upon the concept that a different type of disability can arise, and is compensable, during the pendency of a Petition to Reopen.

To a large extent, this is based upon how the mechanics and purpose of a Petition to Reopen are interpreted. On the defense side, we can take a narrow view of the Petition to Reopen, and argue that its ultimate purpose actually relates to permanent disability, (i.e., if the factors of permanent disability have not changed, there is no ground for reopening).

Applicant attorneys see it somewhat differently and take an expanded view of the term "good cause" and "new and further disability". They note that the Macias case (supra) acknowledge that the term "new and further disability" was not defined, and is thus subject to comprehensive judicial interpretation and definition. This, of course, leaves it pretty much wide open. Macias specifically says that "good cause" does not permit re-litigation of the original award (in other words the Petition to Reopen is not a belated substitute for a Petition for Reconsideration), but good cause for reopening may include a mistake of fact occasion by the failure or inability to produce certain evidence; a mistake of law disclosed by subsequent appellate review; inadvertence; newly discovered evidence

that is not cumulative; or fraud, perjury, or false statements. Admittedly, when we start talking about mistake or inadvertence, defendant's position must obviously be that this is an attempted re-litigation of the prior award, and is not permissible. Fraud, perjury, and/or other criminal activity resulting in the issuance of an award, is something else altogether, but the most common Petition to Reopen that we all confront is the one based upon a claim of new evidence {i.e., some ground not within the knowledge of the Appeals Board at the time of making the former award or orders which renders said original award or orders inequitable. Macias, supra; Walters v. IAC, 22 CCC 67 (1962)}.

From applicant attorney's standpoint, any change in circumstance or change in condition justifies the Petition to Reopen. Thus, if applicant participates in medical treatment of a different type, intensity, or frequency, or experiences any kind of change in his condition, {including a change of circumstances, such as an inability to participate in rehabilitation, LeBouf v. WCAB, 34 Cal Appl. 3d 234 (1983); C & C Industries v. WCAB (Fraga), 66 CCC 1186 (2001)}, this would be enough to legally justify a reopening. As a practical matter, very many of these injured workers would just as soon sue their own attorneys as their employers (it was noted in another section that the highest percentage of complaints to the State Bar are in the area of workers' compensation), so we are probably going to see a Petition to Reopen in virtually every case involving a Stipulated Award, unless the applicant specifically instructs his attorney not to file it (and the attorney has iron clad documentation in his file to protect himself).

The Petition to Reopen is also a method of addressing the withdrawal of a dismissal of an Application for Adjudication of Claim, so long as this is done within five years. Nolan v. WCAB, 42 CCC 401 (1977); Azadigian v. WCAB, 57 CCC 391 (1972).

Although the petition must be filed within five years, the statute of limitations is an affirmative defense, and a defendant can waive it if it is not raised and pled. Guild v. WCAB, 64 CCC 175 (1999); Labor Code §5409. Even if the statute is pled, estoppel to raise it may apply (basically, in the case where the defendant misleads applicant in to believing that filing a Petition to Reopen is not necessary. Industrial Indemnity v. IAC (Varela), 18 CCC 39 (1953); Brenner v. IAC, 10 CCC 110 (1945); Nolan v. WCAB, 42 CCC 401 (1977). Estoppel situations are likely to be pretty much fact specific, but applicant attorneys were noting that it might apply in certain situations if required notices were not given, i.e., Rule 9812(f), for example, requires that a notice of estimated permanent disability is required, and a failure to give notice of such an estimate may give rise to estoppel (in a situation where a treating doctor found additional permanent disability after the issuance of an award).

There are certain types of cases, such as asbestos/progressive disease-type cases, over which the Board may retain continuing jurisdiction beyond the five years (on the ground that the condition never really does become permanent & stationary). General Foundry v. WCAB (Jackson), 51 CCC 375 (1986), and we note that there was a push by some judges a number of years ago to attempt to reserve jurisdiction over temporary disability in ordinary orthopedic-type cases, but such a reservation of jurisdiction is not permissible. Ruffin v. WCAB, 52 CCC 335 (1987).

There are certain procedures after the expiration of five years which do not require a Petition to Reopen, such as entitlement to ongoing medical care, including compensable consequence medical care (an orthopedic disability at some point requiring psychiatric care) {Liberty Mutual Insurance Company v. WCAB (Griffin), 48 CCC 36 (1983); benefit enforcement and penalty proceedings (Llewellyn Iron Works v. IAC (Crider), 19 IAC ____ (1933); proceedings involving

only mathematical calculations (commutations, credit proceedings, reallocating attorney fees (Sanchez v. WCAB, 55 CCC 179 1980); including the adjustment of the payment of death benefits to dependents in accordance with their respective needs (Labor Code §4704), and perhaps the automatic increase of death benefits to correspond with the applicable temporary disability rate (assuming this is warranted by a decedent's wages), Phillips v. Sacramento Municipal Water District, 63 CCC 585 (1998)}. It should be noted that a defendant is responsible for a supplemental attorney's fee if it brings an unsuccessful Petition to Reopen and Reduce (Labor Code §5410.1), and likewise is responsible for attorney fees if it files an unsuccessful Petition to Terminate Temporary Disability (Labor Code §4651.3); an unsuccessful Petition to Terminate an Award of medical care (Labor Code 4607); or if it refuses to provide medical care pursuant to a Findings & Award (unsuccessfully), even after expiration of the five-year statute (based upon the ground that the carrier has constructively filed a Petition to Terminate medical care). United Airlines v. WCAB (Dickerson), 64 CCC 1511.

VII.

INVESTIGATION, DISCOVERY, PROCEDURE, AND OTHER ISSUES

With respect to depositions, there were suggestions that attorneys counsel their clients to avoid the "I don't know" answers for the obvious reason that, if applicant does not know, defendants have the power to explain what it is they don't know (sometimes the most damaging depositions are the ones where the evasive applicant does not know or does not remember a thing).

There is also some question with respect to whether, in light of Collins v. Superior Court, 66 CCC 706 (2001), applicant attorneys should avoid having their client's review and sign deposition transcripts. In Collins, it was held that an applicant could not be convicted of perjury based upon

non-compliance with Penal Code §124, which essentially stated the deposition was not complete until it had been delivered to applicant "with the intent that it be uttered or published as true". In Collins, the deposition had not been delivered to or signed by applicant. It was pointed out, however, that Collins was as much of the result of an inept prosecutor as anything else, since the prosecutor in that case did not alternatively plead insurance fraud, pursuant to Insurance Code §1871.4. It was noted that these fraud provisions do not have any similar publication requirements, and that the crime of workers' compensation fraud is complete the moment the statement is uttered during the course of the deposition. As a practical matter, if an applicant refused to review and sign his deposition, we would probably make a real issue of that point at the time of trial.

Also related to the subject of depositions, was the subject of "coaching". There seems to be grudging agreement that blatant coaching is unethical. An attorney's ethical obligation to his client ensures that applicant's interests are protected by his attorney asserting the appropriate objections (provided these objections are asserted in a manner that is consistent with the truth. In other words, making an objection which suggests the answer is probably improper) and while it is certainly proper for an attorney to interrupt a deposition for the purpose of consulting with his client, it is improper if the purpose of that consultation is to tell his client how to answer the question.

Also on the subject of discovery is a relatively new case, Yee-Sanchez v. Permanente Medical Group (Piatt v. Eureka union School District) , 68 CCC 637 (2003), which stands for the proposition that it is inappropriate for the parties to seek a judicial process to compel discovery prior to the filing of an Application for Adjudication of Claim. The court essentially held that the Workers' Compensation Appeals Board has no jurisdiction to do anything (at least in a post-January 1, 1994 proceeding) prior to the filing of an Application for Adjudication of Claim (it cannot compel

discovery, not can it order a defendant to file an Application), and the gist of the opinion is that to attempt to use a judicial process for discovery prior to the filing of an Application could result in sanctions, and the striking of any evidence obtained.

The question, of course, relates to exactly what is a compelled judicial process. Obtaining statements, or an authorization from an injured employee with respect to medical records, is probably permissible. Even though it might be argued that an applicant voluntarily appears for a deposition in response to a notice, the argument can very easily be made that the notice, taking the form of a judicial pleading, to an extent "compels" applicant to appear, so we really think that the better practice at this point is to avoid taking the deposition of an applicant in the absence of the filing of an Application for Adjudication of Claim (one of he situations in the cited case involve the attempted taking of a doctor's deposition, and for some time we have known of cases indicting that that is improper in the absence of the commencement of a formal proceeding before the Board).

On the subject of sub rosa, Rule 10601 requires that all sub rosa video must be served on applicant's attorney prior to the time of the Mandatory Settlement Conference, or it cannot be used (subsequently obtained sub rosa would be subject to the limitation that it was not available prior to he time of the MSC, i.e., there must be some reason why the sub rosa could not have been obtained prior to the MSC). A discouraging case is Headshots/Glamour Portraits v. Workers' Compensation Appeals Board (Clowdus), 61 CCC 512 (1996), in which it was held that sub rosa film could not be used to rebut the presumption of compensability where, among other things, defendant did not show why it could not obtain the films prior to the expiration of the 90 days (although this case also involved disclosure problem as well).

On the subject of rehabilitation, we did find it interesting that at least one of the panelists was advocating determining an applicant's qualified injured worker status at the time of the initial intake interview, which certainly suggests that it is the expectation of applicant attorneys that any applicant can be made to be a qualified injured worker, and discloses the extreme bias in favor of applicants on this particular issue. Essentially, the determination of whether or not applicant is a qualified injured worker really has no basis in reality and applicant attorneys expect that their doctors will routinely find applicants to be qualified injured workers if desired, and the Rehabilitation Unit will routinely rubber-stamp its approval of those determinations. Basically, there is no relation to reality here. As a practical matter, serious consideration to settlement of rehabilitation pursuant to new Labor Code §4646(b) authorizing settlement of the benefit for up to $10,000.00 (under prescribed circumstances), may be considered.

Despite the lip service paid to the legislative intent of returning applicants to their previous employers, we all know that the Rehabilitation Unit and the Workers' Compensation Appeals Board has made this increasingly difficult. In Jack-in-the-Box v. WCAB (Morrison), 68 CCC 9 (2003) (an opinion certified for non-publication), the court essentially held that an offer of modified work accompanied by a job description was not enough, but that the offer of modified work must include a description of the activities to be performed, the physical requirements necessary to complete the activities, the length of the required work activity, the rate of compensation, the location where the work is to be performed, the job title, and as showing that the offer involves work at a regular position related to the employer's business objectives. Funny, none of these requirements seem to be set forth in Labor Code §4644(a)(5) and (6).

The statute of limitations for vocational rehabilitation is generally five years from the date of injury, or one year from the date of the first Findings & Award or approval of a Compromise & Release {Labor Code §5405.5; Bekins v. WCAB (Hansen), 47 CCC 1260}.

There was a very significant lien case involving Medi-Cal, Boehm & Associates v. WCAB (Brower), 68 CCC 548 (2003). This case held that Welfare & Institutions Code §14124.791 applies to settlements in workers' compensation proceedings (it was initially thought to apply only to third-party proceedings). This section generally provides that the Medi-Cal lien shall be reimbursed for the reasonable value of benefits provided, but not to exceed one-half of the beneficiaries' recovery. The downside of this section is that it also provides that the actual provider of the service (the hospital or doctor) may recover for all fees related to the services provided to he beneficiary, if "the provider has made a full reimbursement of any fees paid by the Department for those services." With respect to this latter provision, this essentially means that the provider may seek reimbursement for its usual and customary fees. Although, at some point before it receives those fees, it must reimburse the Department of Health Services for all Medi-Cal benefits received (we think this must be done prior to an Award, although the court does not really specify a time-frame).

In this particular case, the carrier was out of luck, since his Compromise & Release indicated it was settling around the Medi-Cal lien and, under those circumstances, Medi-Cal was entitled to full reimbursement (assuming it established industrial injury, and that the medical services were related to that injury).

We think, obviously, this only applies to Thomas waiver-type cases, but if a defendant wishes to take advantage of this section, we think it going to have to be handled very much like a Baird or Gregory proceeding (i.e., it is going to have to be written in to the Compromise & Release and

approved by the workers' compensation judge. This may, of course, cause some delay in approval of the settlement document, but certainly would be worthwhile in a low dollar Thomas waiver settlement where a defendant may be faced with a very high Medi-Cal lien.

Also on the subject of investigations, it is noted that where death results from an otherwise accepted industrial injury, defendant may be entitled to another 90 days to investigate after notice of the claim for death benefits. Wong v. CIGA, 31 CWCR 18, but that there is an expedited hearing/conference procedure for dealing with denied injury claims {Rule 1055 and Labor Code §5502(e)}. It is noted that it is now permissible to arbitrate all issues under Labor Code §5275(b), although obviously arbitration fees are going to be imposed.

Finally, we may be seeing some additional involvement by the Employment Development Department. At least one of the panelists was encouraging applicant attorneys to have their client file state disability claims in all cases, if for no other reason, that the Department would pay the difference between the temporary disability rate and the state disability rate, or will supplement permanent disability benefits up to the temporary disability rate so long as benefits are available. Obviously, especially in the case where permanent disability benefits are being supplemented, the Department's lien will apply against applicant's eventual recovery.

Finally, please recall that benefit printouts must be provided to applicant attorneys on demand (although no more often than 120 days) and must be provided at every conference (as a matter of course, if you have a conference on calendar, fax a copy of your itemized benefit printout to your attorney or representative, without even thinking about it). Judge Kahn, on one of the panels, suggested that compliance with this rule left something to be desired, and that future sanctions were a possibility.

VIII.

CONCLUSION

We suppose the burning question is whether we will all survive until the next convention. Hopefully, we will. We would be tremendously surprised, however, if there were not some significant changes coming in to effect soon, particularly in the area of containment of medical costs.

To a large extent, we are all still exploring our way through the new rules and statutes, and hopefully, we will be able to proceed with somewhat more confidence as time goes on.

In the meantime, if you have any questions with respect to the material referenced in this report, or would like us to speak and/or conduct seminars with respect to this subject matter, or any other issues, please contact us, and we will be more than happy to help out.

We thank you for the opportunity to have been of assistance to you.

Very truly yours,

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