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THE DEFENSE PERSPECTIVE AND OBSERVATIONS OF THE CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION

SUMMER CONVENTION, 2004

SQUAW VALLEY, CALIFORNIA

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2004 SUMMER CONVENTION OF THE CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION (June 17, 2004 - June 20, 2004)

<u>TO OUR CLIENTS</u>:

We had the opportunity to attend the Association's 2004 Summer CAAA Convention. As expected, the overriding topic of discussion was the Workers' Compensation Reform Legislation recently enacted as Senate Bill 899 (effective April 19, 2004).

The legislation has had a more or less sobering effect on this convention, but most of the panelists approached the problem of what to do with the new legislation with a certain amount of bravado. However, it was clear from the comments made during the legislative session that the Association and its supporters view SB899 as a major setback in connection with which they need to regroup. It is unclear just who they have as a legislative ally at this point, other than the few individuals who voted against SB899. These individuals spoke in terms of work on future legislation (over the next year or years) to attempt to regain some of what has been lost. On the other hand, it was acknowledged that some of the more business-oriented factions in the Legislature are not satisfied with the extent of the reforms contained in SB899, and are looking to make further inroads, perhaps even by way of a future initiative.

All in all, the general theme of this convention was to learn the new law, learn ACOEM, and learn the AMA Guidelines upon which the future permanent disability schedule will be based, and then adapt to those.

We had some questions with respect to how to format this particular report. In previous reporting (with respect to the 2004 Winter Convention, and in the recent summary sent to our clients several weeks after the adoption of SB899 -- if you do not have these documents, please advise, and we will send them to you), we had summarized and analyzed both SB899 and its predecessor statutes contained in SB228 and AB227 (and, as a practical matter, all of these enactments need to be considered together, almost as two parts of the same statutory revision, rather than two separate reform attempts). To attempt to redo all of that here would cause this report to become unwieldy. Thus, what we are going to do here is focus on the Association's interpretations and/or intentions with respect to some of the more important aspects of the law.

Their overview begins with the observation that carriers, in almost all cases, will find themselves required to set an immediate $10,000.00 reserve based upon requirement of Labor Code §5402(c) that an employer authorize medical care up to $10,000.00 one day after the filing of a claim form. They also suggest that, although penalties have been drastically reduced, Labor Code §5814.5 is still good law, which allows a reasonable attorney's fee in a case where a penalty is won (although this would appear to apply only in post-Award situations), and in many cases the attorney's fee would exceed the amount of the penalty itself.

There is also some discussion among the members that they may start looking for other attorney fee sources, more specifically, temporary disability benefits. Certainly there will be issues with respect to temporary disability, which is now subject to an approximately two-year cap under Labor Code §4656, although the panel has noted that the cap is measured from "the date of commencement of temporary disability payment", raising an issue of whether applicant could actually collect temporary disability for a longer period of time if the carrier initially refuses to pay, and applicant collects state disability benefits.

In the case of reopenings of prior awards for new and further disability, questions were raised with respect to which permanent disability and medical treatment rules would apply (although, since the prior award effectively fixes liability, and the only issue is whether the disability has increased, we think it is pretty clear that the old permanent disability schedule and rules would apply, although we think the new medical treatment rules apply to everything, including future medical treatment awards.

It is interesting to see that the Association members are as confused as we are with respect to the present status of medical/legal evaluations. Everyone acknowledges that new Labor Code Sections §4060 through §4062 purport to be effective as of the date of enactment, or April 19, 2004, although the quandary is that these sections, in represented cases, require that the mechanism set forth in Labor Code §4062.2 be used, and that section will not be effective until January 1, 2005 (and, in fact, says it only applies to injuries occurring after January 1, 2005). Panelists noted that the Association's members are variously going down a number of roads: business as usual; obtaining agreements with the other side, that each side can obtain QMEs whose reports will be admissible; agreeing to Agreed Medical Examiners (the one thing upon which everyone can agree is that an

Agreed Medical Examiner's report is admissible at any time); or that there is simply no statutory authority for obtaining a medical/legal evaluation at this time, so the only medical reports which are admissible are treating doctor reports (and, as so classified, the utilization review reports prepared in connection with treatment recommendations).

Although this legislative defeat has certainly knocked some of the wind out of the other side, our impression from the convention is that they are by no means out, and it appears they are going to attempt to be rather creative. What we consider to be judges' natural tendencies to give applicants the benefit of the doubt, may allow some of these strategies to work.

With this in mind, we will take a look at some of the more analyzed issues.

A. **MEDICAL CARE AND TREATMENT**:

The one thing upon which it appears everyone agrees is that the treating doctor presumption of correctness is finally gone for all purposes and in all cases as of April 19, 2004 (Section 46 of SB899).

There does seem to be a lot of concern with respect to the medical provider networks, the primary concern being that, as between the medical provider networks and utilization review, carriers will attempt to evade or escape their liability to provide medical treatment to injured workers. This is ridiculous, of course, but the other side does view us with suspicion.

Until the medical provider networks begin to come on-line as of January 1, 2005, in most litigated cases, we will still be dealing with an applicant's free-choice physician. Thus, for the immediate future, the battles over medical care are going to be in connection with utilization review. Medical treatment which is reasonably required to cure or relieve from the effects of an industrial injury is defined as treatment that is based either the administrative utilization review guidelines or,

until they are adopted, the American College of Occupational and Environmental Medicine Occupational Medicine Guidelines (ACOEM). These guidelines (after March 22, 2004, which means now) are presumed correct, although this is a rebuttable presumption affecting the burden of proof. Labor Code §4604.5. This section goes on to say that the presumption is controvertible only by a preponderance of evidence establishing that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of his or her injury (an interesting inconsistency, here the statute uses the words "cure and relieve", even though §4600 imposes the obligation to provide medical treatment required to "cure or relieve"; the effect of this is unknown).

The ACOEM Guidelines themselves state that guidelines can be "evidence-based only to the extent that there is appropriate scientific literature on which they can be based." The Association's panelists suggest that the ACOEM guidelines should not apply to most forms of medical treatment, at least in the later stages of medical treatment. They argue that by its own terms, ACOEM applies only to acute and subacute injury, and not chronic injury, and ACOEM appears to accept that the acute/subacute stage ends, and chronicity (pain persisting beyond the usual course of healing of an acute disease or beyond a reasonable time for an injury to heal) follows a definitional time frame of about three months. In Chapter 6 of the ACOEM Guidelines, the guidelines apparently provide that if treatment is for chronic pain, rather than acute pain, the guidelines do not apply.

From our standpoint, although the guidelines might state this, the Legislature does not, since the statutes specifically make the guidelines applicable to all forms of medical treatment except, of course, those situations where the guidelines specifically do not apply, (for example, medical hardware, unfortunately), and in those cases, Labor Code §4604.5(g) provides that authorized

treatment shall be in accordance with other evidence-based medical treatment guidelines generally recognized by the national medical community that are scientifically-based.

This does, however, give applicant attorneys the opportunity to argue that the guidelines, perhaps as they apply to certain types of chronic conditions, are not evidence-based, and one of ACOEM's members suggest that the support for such an argument would be a treating physician report setting forth a compelling rationale for deviating from the guidelines. Assuming this can be done, ACOEM's executive director sees no guideline related reason why his treatment recommendation should not be approved.

Thus, we are going to see applicant attorneys educating their doctors to write reports which clearly define the diagnosis, clearly define the treatment that has been given, and the results obtained, clearly define the treatment for which authorization has been sought, and describes why that treatment is reasonably necessary to cure and relieve from the effects of injury, indicates whether the treatment is offered for injury covered by ACOEM or why it not covered (i.e., it is directed for a chronic condition, rather than an acute condition), questions whether the denial is accurately based upon reliable evidence (there are several categories upon which a denial can be based, so-called category "C" or "D" denials, which are seen more as being consensus-type opinions, rather than actual scientific ones), sets forth alternative, evidence-based, peer-reviewed, and nationally recognized standards of care, and explains how the recommended treatment is best intended to restore functionality and return the injured employee to work. It is noted that there are actually a number of other nationally based medical treatment guidelines available on the Internet, and we suspect that, to the extent that these guidelines conflict with ACOEM, they will be used.

The identified Internet sources were:

www.chchrane.org/reviews/clibintro.htm;
www.cochrane.org;
www.guideline.gov;
www.merckmedicius.com .

It is felt these guidelines are admissible as evidence pursuant to Labor Code §5703(h), which indicates medical treatment protocols are admissible.

Applicant attorneys will be taking a very close look at the contents of the Notice of Denial (the basic requirements are set forth in Rule 9792.9 in the Rules of Practice and Procedure. We have had discussions with a numbers of clients with respect to the contents of this notice, and, in a litigated context, do not feel we can prevail with the simple conclusionary denial, at least in the face of a somewhat reasoned treating physician's report). A recent Opinion and Order Granting Reconsideration from the Appeals Board in the case of Leon Smith v. Churn Creek, WCAB Case Number RDG 0111743 (unfortunately, apparently unpublished so a copy of the opinion is included at the end of this report) does a very nice job in setting forth what the Board apparently feels is required in the denial of certification after utilization review. In this case, the treating doctor recommended epidural injections, and the reviewing physician, utilizing the ACOEM Guidelines, first identified himself and his function and capacity, the specific form of treatment that was being proposed, his decision (authorization denied), the reason for his decision, explaining how the guidelines applied in this case, and citing the actual guidelines. He invited a response and, in fact, prepared a supplemental response further defining the guidelines upon which the decision was based. Neither applicant's treating doctor, nor his consults, were able to offer persuasive evidence to overcame the guidelines (their essential argument was that applicant should be afforded all available

modalities to treat his pain). The trial judge's decision to allow the treating doctor to proceed with treatment in the face of the utilization review denial was reversed by the Board.

The case is instructive with respect to what we think it will take to establish a presumption of correctness in favor of a particular guideline and utilization review recommendation (it is noted that as the guideline itself carries the presumption, not necessarily the recommendation based upon it). Workers' compensation judges have historically looked for ways to allow treating doctors to do anything they wanted. We suspect old habits will be hard to break.

Please also note that there are three types of reviews: Prospective review (pretty much self-explanatory), Concurrent review defined as review conducted during an inpatient stay (Rule 9792.6(a)(3) of the Rules of Practice and Procedure), and in this case medical care cannot be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed-upon by the physician that is appropriate to the employee's medical needs, [Labor Code §4610(g)(3)(b)]; and retrospective [review conducted after medical services have been provided, Rule 9792.6(a)(10). This latter type of review will have special application in cases involving self-procured medical treatment, possibly in cases where injury AOE/COE is initially denied]. If nothing else, this may well put the brakes on some of the ridiculous medical churning we have been seeing from self-procured physicians (as well as from a number of free-choice physicians).

You can probably expect technical challenges to utilization review recommendations as well, perhaps based upon claims that the treatment services recommended were not within the licensure and scope of the physician's practice recommended by proposed Rule 9792.7(b)(2) (while the medical director will certainly be a California licensed physician, we expect the challenge will be

that his specialty is not appropriate to conduct the review); and you can probably expect time frame compliance contests.

One of our clients astutely observed that if the treating physician's proposed treatment is not certified by utilization review, the carrier/employer appears to be under an obligation to notify applicant of his panel QME rights along with a denial of medical treatment. Rule 9792.9 of the Rules of Practice and Procedure suggest that merely advising the employee that the provisions of Labor Code §4062 are available to resolve the dispute might be sufficient, but the Association feels that §4062(a), which provides that "if either the employee or employer objects to a medical determination made by the treating physician," appears to obligate the employer to notify applicant of his panel QME rights at the time he is notified of the decertification. At least some of the Association members feel that the burden is on the carrier to initiate the Labor Code §4062 AME/QME process if utilization review rejects a treatment procedure.

Quite frankly, we would not anticipate as many utilization review problems once the medical provider networks come on line after January 1, 1995. While the Association appears to be resigned to these networks, their primary concern at this point appears to be whether or not applicants with current free choice physicians can be forced into the networks once they come on line. It is noted that new Labor Code §4600(c), which is effective as to all dates of injury as of April 19, 2004, provides that an applicant can free-choice a physician unless the employer has established a medical provider network. The literal interpretation of the statute does not appear to create an exception for an applicant who already has a free choice physician, and certainly lends itself to a suggestion that an employer can force an applicant into a medical provider network following its valid creation, even if an applicant has previously chosen a free-choice physician. The suggestion of the panelists is that

they will be exploring very closely the technical aspects of the creation of these networks, to assure they are properly set-up within the terms of the statute.

There is also a question with respect to whether an employee is capable of escaping from the network in ways other than the independent medical review process. They suggest that an employer's failure to timely comply with Labor Code §4601 (tendering a change of physician within 5 days of an employee request), or a failure to properly allow a free-choice of physicians within the network, could allow an applicant to free choice a physician outside of a network. These, of course, are all issues on which there is presently not much guidance (although, at least with respect to the Labor Code §4601 argument, that has allowed applicants to escape the employer's initial 30-day control period).

One final note with respect to medical treatment. There does seem to be a general consensus that if you have an Agreed Medical Examiner, the recommendations of that examiner are going to control the course of the treatment (in other words, if the Agreed Medical Examiner's recommendations were in conflict with the guidelines, they would be considered compelling medical evidence to the contrary). We also think that, like in the case of the former treating physician presumption, a presumption in favor of the guidelines is eliminated by the use of an Agreed Medical Examiner.

B. PERMANENT DISABILITY AND REHABILITATION:

The new permanent disability schedule, due on January 1, 2005, is to incorporate the recommendations of the American Medical Association guide to the evaluation of permanent impairment, per Labor Code §4660. Subsection (d) suggests that the new permanent disability schedule, once adopted, may apply to all dates of injury if there were no medical reports

demonstrating permanent disability in those cases prior to the date of adoption. It is noted that, fairly recently, a number of applicant's free choice doctors had been submitting generic-type reports stating that the doctor anticipates there will be permanent disability arising out of the industrial injury, although the applicant remains under treatment and temporarily disabled, and it is thus not possible to forecast the degree of applicant's permanent disability until such time as he or she is permanent & stationary. We think this is an attempt to circumvent the possible application of this statute to pre-schedule injuries, although we do not believe this is the type of permanent disability report which the statute has in mind.

The AMA Guidelines are used as a basis for evaluating impairment in a number of jurisdictions, including Longshore cases. The guides themselves suggest methods of evaluation starting with an impairment evaluation, defined as an independent, unbiased assessment of the individuals medical condition, including its effect on function and applicant's ability and limitation performing activities of daily living, communication, physical activity, sensory function, non-specialized hand activities, travel, sexual function, and sleep. To determine the whole body impairment, related but separate conditions are rated separately and impairment ratings are combined using the combined values chart [there was some suggestion that the multiple disability table may have been unintentionally abolished by reason of the apportionment rules set forth in Labor Code §4664(c)(2), but this would suggest otherwise], unless criteria for the second impairment are included in the primary impairment (essentially, what we would interpret as overlap). There is a suggestion that the medical evidence should be sufficient to verify that the impairment being claimed actually exists (what we might want to call the objective medical evidence test), and the resulting report must describe the residual function and impact of the medical impairment on the ability to

perform activities of daily living, complex activities, the medical consequences of performing such activities, a rationale, and the comparison of medical findings with the impairment criteria in the AMA Guides and a calculation of the impairment rating, together with a rationale as to how it is calculated.

Using the AMA Guides with respect to the spine is enlightening: Category I, or a zero impairment, is subjective findings only (in other words, subjective complaints would not appear to generally register on the AMA impairment scale); Category II, 5% to 8%, consists of objective findings, such as muscle guarding, spasm, loss of range of motion, or non-verifiable radicular complaints, or an imaging study demonstrating a herniated disc with resolved radiculopathy, or fractures with less than 25% compression; Category III, 10% to 13% impairment, is radiculopathy with objective verification (with notations that some objective medical evidence of spinal impairment, such as spondylosysis, spondylolithesis, and herniated disc without radiculopathy are actually fairly frequently found in populations over a certain age even in the absence of trauma); Category IV, 20% to 23%, is significant loss of motion, a fracture of greater than 50% compression and possible successful or unsuccessful attempt at surgical arthrodesis; Category V, 25% to 28%, meeting the criteria of the previous categories, with significant lower extremity impairment being present as indicated by either atrophy or loss of reflex, pain, and/or sensory change. Typically, by today's standards, a category II impairment would probably warrant work restrictions taking in the range of a 30% standard.

There may be some difficulty applying the guides to psychiatric disability, since, although they instruct how to assess abilities to perform activity of daily living, they do not include numerical impairment ratings, as it is said there are no precise measures of impairment and mental disorders.

The guides apparently recognize four areas of functional limitations: activities of daily living, social functioning (the capacity to interact appropriately and communicate effectively with other others); concentration, persistence and pace; and adaptation or deterioration or decompensation in complex work settings.

The AMA's Guides apparently contain some suggested standards: total loss of bladder control-40% to 60%, inability to breath without a respirator-90%, total loss of use of the upper extremities-80%; inability to care for one's self in any situation or manner due to brain injury-70% to 90%; Alzheimer's with impairment requiring assistance and supervision for most activities of daily living -30% to 49%; mental disability with severe limitation of all daily activities requiring total dependence on another person-70% to 90%, irreversible brain coma requiring total medical support - 70% to 90% (source: AMA Guides 5th edition, pages 311, 319, 321, 325, 396-97). Obviously, using the straight AMA Guides without modification, would appear to make 100% total disability somewhat difficult to achieve, short of death.

In a Longshoreman's context, 33USC Section 908 actually sets forth the number of weeks of compensation payable for various specific injuries (mostly amputation), and actually in some cases, would result in much greater compensation than would be available to an applicant under the present California schedule.

Although the consensus at the convention was that the application of the AMA Guidelines would probably result in about a 30% reduction in overall permanent disability (this is apparently an opinion shared by the Disability Evaluation Unit), it is actually unclear exactly where these reductions will come from. First, the statutory mandate is only that the new permanent disability schedule be based upon the AMA Guidelines; not necessarily adopt them literally and verbatim. In

fact, Labor Code §4660(a), also mandates that the nature of the physical injury or disfigurement, occupation of the injured employee, age at the time of the injury, and the employee's diminished future earning capacity all be taken in to consideration in the formulation of the schedule. This leaves a lot of room for discretion, and we suspect that applicant attorneys will be lobbying the Administrative Director hard in connection with its adoption.

One consensus is that a part of the overall increase in permanent disability will be due to the elimination of subjective complaints (or at least a minimization of their importance) in connection with permanent disability. Another method may come from the manner in which Labor Code §4658(d), now calculates permanent disability. Under 15%, the number of weeks awarded for each percent of permanent disability are less than they were in the past, and applicant attorneys suggest that the crossover point where benefits under the new permanent disability calculations equal the benefits paid under the old calculations is at 72%. Quite frankly, we really were not reading the schedule in the same manner, as it was our thinking that anything at 70% or above was significantly more than benefits paid under the old calculations. There seems to be some assumption by the convention that the bottom end weeks may figure into the calculations for the higher end disabilities, which would thus have the effect of reducing the actual exposure under the life pension-type disabilities. We think we are just going to have to wait and see the Administrative Director's payment schedules.

One of the interesting contentions, however, relates to rehabilitation. The convention panelists are not at all sure that rehabilitation is dead, especially with the Labor Code's directive that the ACOEM Guidelines be used (although, admittedly, this is only a temporary situation until the Administrative Director adopts his own utilization review guidelines). ACOEM actually states that

rehabilitation is a therapeutic mode to be used in chronic cases. Thus, the panelists were urging association members to give consideration to demanding vocational rehabilitation as a mode of reasonable and necessary medical treatment under ACOEM. There is also a suggestion that, if rehabilitation is not available, this could well impact earning capacity, one of the factors to be considered in determining an applicant's permanent disability under the new schedule. The theory is that, if a person cannot be retrained, he will certainly have less earning capacity and thus a greater impairment.

Following up somewhat on several of the major topics at the last convention, it is thought that, in the absence of vocational rehabilitation, an employer will be perceived to have a greater duty to provide modified or alternative work, or reasonable accommodations, and that the failure to do so may trigger substantial civil liability under either the ADA, or the California Fair Employment & Housing Act.

In connection with rehabilitation, there was a very recent significant case, Pebworth v. WCAB, 69 CCC 199 (2004), a Court of Appeal case considering the retroactive application of amendments to Labor Code §4646 which permitted the parties to settle prospective vocational rehabilitation benefits for lump sums up to $10,000.00. The case involved an industrial injury which pre-dated the amendments to Labor Code §4646 which permitted such settlement (it was effective January 1, 2003), and the Rehabilitation Unit (and Workers' Compensation Judge) took the position that the statute was not retroactive. The court of appeal disagreed, finding that the amendments were procedural in nature, and, thus could be applied retroactively (a statute is procedural if it merely provides a new remedy for enforcement of existing rights, and substantive if it imposes new or additional liability; this distinction could well become important in connection with SB899). The

long term relevance of this case would probably relate to this procedural/substantive distinction. Its specific application with respect to rehabilitation benefits will be limited, since Labor Code §4646 was repealed as of January 1, 2004. Thus, there would appear to be no statutory authority for settling exposure for Labor Code §4658.5 supplemental job displacement benefits (the so-called "vouchers"), which are specifically earmarked to educational expenses (and, we suspect under most circumstances, would not be payable to applicant).

C. APPORTIONMENT:

This particular subject was a recurrent theme during the various seminars. It is clear that the applicant's side of the Bar is greatly concerned about the new apportionment statutes, and they recognize the defense position (and even concede a number of judges are accepting that position) that pathology is now a factor in determining apportionment. They are not going to accept this without a tremendous fight, however.

Their initial suggested attack is based upon an argument that the repeal of Labor Code § 4750 and §4750.5, coupled with the adoption/amendment of Labor Code §4663 and §4664 do not effect a change favorable to the defense at all, and in fact, leave the apportionment rules pretty much as they existed prior to the adoption of SB899. The basic argument is that the statutes do not allow apportionment to pathology or medical etiology, because Labor Code §4664(a) specifically states that "the employer shall only be liable for the percentage of permanent disability directly caused by the injury". Thus, the argument is that the statute specifically refers to causation of disability, rather than causation of underlying disease, which is really no change from previous law.

This is an interesting argument, but to an extent it overlooks the fact that four statutes regarding apportionment were radically overhauled by the Legislature. Borrowing a precept from

one of the psychiatric cases, Lockheed Martin v. WCAB, 67 CCC 245, when statutes are significantly changed by the Legislature, one should assume that the Legislature intended to effect a significant change in the law. There would be no reason for this wholesale change to four different statutes if the Legislature did not intend that the rules with respect to determining apportionment be significantly changed.

An interesting corollary to this argument is that the seminal case on how apportionment is to be applied, Fuentes v. WCAB, 41 CCC 42 (1976), is dead with the repeal of Labor Code §4750, since Fuentes was specifically based upon that statute. Fuentes stood for the proposition that apportionment was determined by the "subtraction" method, i.e., the amount of apportionment was determined, and then subtracted from the overall disability, with the result being the percentage of applicant's actual, industrial disability. Under this calculation, industrial disability always started at zero (i.e., overall disability at 70%, non-industrial apportioned disability at 30%, and the result is an industrial rating of 40%). Applicant attorneys argue that the actual change made by SB899 is to take apportionment off the bottom rather than the top. Thus, for example, in a 70% case, a defendant would get a credit for the underlying 30% disability as against a total 70% disability (essentially, the credit would relate to the monetary benefit, rather than the percentage). In a 100% case, the initial payments to applicant would be at the temporary disability rate, less credit for the payment rate for the underlying apportioned disability, and at some point, that credit would be exhausted and payments at the full temporary disability rate would thus continue for the rest of applicant's life. Balanced against this argument, appears to be a concession that SB899 does limit the rule that medical opinion which merely assesses percentages of responsibility is not substantial

evidence (Pacific Employees Insurance Group v. WCAB, 31 CCC 409; Gay v. WCAB, 44 CCC 817). Labor Code §4663(c) specifically requires the physician to fix the approximate percentages of disability caused both by the direct result of the industrial injury, and caused by other factors, both before and subsequent to the industrial injury. This certainly lends itself to the argument that the apportionment determination is to be done by way of percentages, rather than credits, and although Fuentes may have been considering the application of a now repealed statute (Labor Code §4750) in connection with its conclusion with respect to how apportionment was to be calculated, the general principles upon which that calculation was based still appear to be valid, and from a defense standpoint, there is no reason to concede that Fuentes is not good law with respect to how apportionment should be calculated.

There are certainly going to be issues with respect to the so-called pre-existing, dormant conditions (i.e., pathology) which are lit-up by industrial factors. We think defendants are going to have to be somewhat careful in terms of what they claim, since a perception by the Bench that defendants are overreaching may generate hostility to our position on apportionment. Certainly, as this convention demonstrates, the statutes are subject to some degree of interpretation, and we may want to consider taking a reasonable approach with respect to their interpretation so as to insure that that interpretation is favorable.

Thus, we think we can probably reject the applicant's Bar's position that there is no apportionment to pre-existing, dormant conditions (pathology). On the other hand, we believe that congenital conditions which really have only a tenuous relationship (or no relationship at all) to the industrial injury are not going to be a basis for apportionment, and if we persistently claim that they are, the Bench may develop a perception that the defense is being unreasonable. We do not want

that. Thus, for example, we do not think the bench is going to react favorably to a claim that there should be apportionment to old age or simple obesity (although morbid obesity might play a role, depending upon the nature of the disability). Certainly if pathology is a risk factor for a certain type of disability (i.e., such as a heart disability), an argument can then be made that a person having such a risk factor should have some apportionment of liability to it.

Similarly, where an applicant has a simple back strain, and radiological studies demonstrate the existence of longstanding, severe degenerative disease, we do not think a physician can continue to say that, since applicant denies previous symptomology, there is no apportionment. Under the new law, we believe there most certainly is.

The point is that there is going to be a lot of judicial interpretation with respect to this new law, and we think the key to obtaining favorable interpretations is to be reasonable about what we are claiming. Applicants are certainly correct in their argument that, for the purposes of assessing disability, an employer takes an applicant as he finds him. On the other hand, the new law seems to suggest that where an employee brings some baggage with him, that is going to be taken in to account.

A more serious concern, however, may actually relate to the evaluation of prior disabilities which were the subject of awards. The statute itself initially appears pretty clear, providing that if applicant has received a prior award of permanent disability, it shall be "conclusively presumed" that the prior permanent disability exists at the time of any subsequent industrial injury. [Labor Code §4664(b)]. Unfortunately, the section then goes on to state that "this presumption is a presumption affecting the burden of proof." So is it a conclusive presumption or not (a conclusive presumption is one which cannot be contested)? The final sentence certainly suggest that an applicant would be

entitled to offer some sort of proof that the presumption does not apply. Applicant attorneys appear to be correct in their argument that this statute is internally inconsistent, but, from a defense standpoint, we will take the position that the presumption is conclusive, and no amount of evidence can be presented to rebut it.

Once the AMA based schedule comes into effect, however, there are going to be additional problems with respect to calculating the amount of apportionment. Applicant attorneys are greatly concerned, perhaps legitimately, with respect to how disability under the old schedule is to be apportioned against disability under the new schedule (since, presumably, application of the AMA Guidelines will result in less disability under at least some circumstances).

Unfortunately, these are questions to which there are no really guaranteed answers at this point. We are going to have to wait and see how the courts work it out.

D. COMPENSABLE CONSEQUENCE INJURIES:

An outgrowth of SB899 is that applicant attorneys are probably going to attempt to be creative with respect to the injury claims which they file. Thus, they are being urged to look beyond the simple orthopedic injury which brings an applicant in to their office, and to explore his entire employment relationship or other types of illnesses and/or disabilities which may be related to his work. Thus, if an applicant is a long-term employee in connection with a certain occupation, the member were told to look for illnesses or pathological conditions (interestingly, these conditions might not have necessarily in and of themselves stopped applicant from working, and thus may not have been currently disabling) which might arise from those occupations. Thus, in a long-term occupation involving stress, conditions such as obesity, alcoholism, hypertension, diabetes, and depression may all be characterized as arising from the stress of such an occupation.

Even if established as industrial, we think several of these conditions certainly bleed over in to the apportionment section. For example, there are claims with respect to certain occupations which are said to involve environments which light up diseases such as Multiple Sclerosis or Parkinson's Disease. Quite frankly, however, we know of no scientific works which suggest that these pathological conditions are actually caused by employment factors (the studies for the most part, simply say that the effects of the diseases may be accelerated). Applicant attorneys claim that the test for determining the industrial relationship is "reasonable probability", that is, is it more probable than not that occupational factors caused or accelerated the disease process. Liberty Mutual Insurance Company v. WCAB, 60 CCC 134 (1995) (Writ denied); Federal Insurance Company v. WCAB, 60 CCC 422 (1995). If this works for applicants, it should work for defendants: In the cases of degenerative diseases, such as Multiple Sclerosis or Parkinson's Disease where the claim is that the disease process was accelerated, but not caused by occupational factors, is it more probable than not that applicant would have eventually become symptomatic with respect to this underlying disease process in the absence of industrial exposure? These are questions our physicians are going to have to answer, and we are going to have to encourage them to establish time frames and, since these diseases have received a lot of attention, it is possible they will be able to give us reasonable estimates based upon the general population.

There is a second type of compensable consequence case, which actually arises out of an existing claim (and, thus, a separate claim form and/or Application for Adjudication of Claim is not required). These are the cases which involve a psychiatric injury arising out of a physical injury, or the injuries arising out of an automobile accident while applicant was traveling to her doctor for treatment of an industrial injury.

E. PSYCHIATRIC INJURIES:

Much of the attention relates to the limitation on psychiatric injuries imposed by two relatively recent cases, Lockheed Martin v. WCAB (McCullough), 66 CCC 1223 (2002), holding that the threshold requirements (i.e., industrial factors must be predominant as to all causes) for establishing a psychiatric injury embodied by a Labor Code §32008.3 apply to all claims for psychiatric injury, including those alleged as a compensable consequence of a physical injury and Wal-Mart Stores, Inc., v. (Garcia), 68 CCC 1575 (2003), which held that the threshold requirement of six month employment also applies to a compensable consequence psychiatric injury. The attention, thus, turns to whether treatment is required in connection with those compensable consequence psychiatric claims, even when they might otherwise be barred by the Labor Code §3208.3 thresholds. The answer is probably yes, if that treatment is required for the purpose of treating the admitted industrial injury (see Braewood Convalescent Hospital v. WCAB, 48 CCC 566 (1983). Despite what we consider to be very significant changes in the rules regarding apportionment, there still is no apportionment with respect to medical treatment or temporary disability.

In terms of treatment, ACOEM states that its goal is to help occupational physicians and primary care practitioners manage employed patients with acute stress-related conditions of relatively short duration. ACOEM does not really appear to address long-term psychiatric conditions beyond stating that referral to a mental health professional is necessary if symptoms become disabling or persist beyond three months. There appears to be very little guidance beyond that, although the problem may actually be similar to that in the case of physical injuries, i.e., applicant attorney's argument that ACOEM relates only to acute conditions, rather than chronic ones, although the Labor

Code does seem to direct that the ACOEM Guidelines will be applied to both.

In the previous section relating to permanent disability, we describe the four areas of function addressed by the AMA Guides, and these guides also utilize five classes of psychiatric impairment, although they do not specify specific percentages: Class 1, or no impairment; Class II or mild impairment, contemplating that an employee is capable of most useful functioning; Class III, or moderate impairment, compatible with some, but not all useful functioning; Class IV, or marked impairment, indicating useful function is significantly impeded; and Class V, or extreme impairment, indicating that useful functioning is essentially precluded. The question raised by applicant attorneys is, since the AMA Guidelines do not establish percentages for psychiatric impairments, will the Administrative Director retain, in some form, the existing work function impairments. We will see.

Finally, a very significant psychiatric case was PG&E v. WCAB (Bryan), 69 CCC 21 (2004). In this case, the court held that generalized anxiety over the economic future of an employer is not an actual event of employment for the purpose of establishing industrial psychiatric disability. In this case, applicant cited three causes of his psychiatric disability: (1) he had a large amount of money invested in his employer's stock, and the stock price was declining in connection with the energy crisis; (2) downsizing and economic uncertainty of the company, which he felt jeopardized his employment (he was apparently never notified that he would be subject to lay-off); and (3) face-to-face confrontation with disgruntled customers. The court held that the face-to-face confrontation with disgruntled customers was an actual event of employment, and could form the basis of an industrial psychiatric claim, but that applicant's concern over the value of his stock, the economic future of the company, and his general fear with respect to losing his job, were not actual events of employment.

F. OTHER ISSUES:

There are several recent cases which deserve attention in connection with Compromises & Releases. Modifying the effect of Jefferson v. Department of Youth Authority, 67 CCC 727 and Kohler v. Interstate Brands Corp., 67 CCC 1447 (to the effect that, in the absence of evidence to the contrary, a Compromise & Release extinguishes all claims, including concurrent civil claims), we have Mitchell v. The Union Central Life Insurance Company, 69 CCC _____ (2004). This applicant filed a stress claim against her employer, together with a civil claim alleging employment discrimination. At about the time she turned down a $1,000,000.00 offer to settle the civil case, she settled the workers' compensation claim by way of a $57,000.00 Compromise and Release, which made no reference to the civil claim. In resisting defendant's attempt to obtain a dismissal of the civil action based upon the Compromise & Release, her extrinsic evidence was the fact that it would be lunacy to assume she intended to extinguish that claim by way of a $57,000.00 Compromise & Release while she was at the same time rejecting a $1,000,000.00 offer. The Court of Appeal agreed, and reinstated her civil action. While there is some thought that this conflicts with the Kohler decision, we think the difference actually relates to the character of the evidence presented.

The second case is County of San Joaquin v. WCAB, 69 CCC _____ (2004), in which a pro per applicant delayed substantially before signing a previously-delivered Compromise & Release. The result was that permanent disability advances continued during the interim period of time, and, thus, at the time the Compromise & Release was actually approved, were significantly in excess of the amount stated on the Compromise & Release (which contained a written caveat that the amount set forth was less credit for further PDAs).

Quite frankly, we do not understand the trial judge's problem, but he ruled defendant could not take credit for advances beyond those set forth in the Compromise & Release. The Court of Appeal (the opinion is non-published) appropriately disagreed. A panelist suggested that the problem here was that the defendant failed to make a benefit printout available to the pro per applicant at the time of the second Mandatory Settlement Conference (at which time the Compromise & Release was approved), and urged that the Board adopt rules denying defendants the right to a permanent disability credit where such an accounting was not produced. This, of course, is an overreaction: our simple solution would be to not settle the case.

In a significant case for the California Insurance Guarantee Association, CIGA v. WCAB, 69 CCC 183, held that CIGA is not obligated to reimburse the Employment Development Department for state disability benefits, since such a claim by department is specifically excluded from the definition of covered claims by reason of Insurance Code Section 1063.1(c)(4). It appears the Supreme Court has now denied a hearing with respect to this case. The specific facts of this case involved a claim where AOE/COE was denied. Theoretically, however, the rationale of the case could apply to any post-Compromise & Release claim in which the Employment Development Department asserted a lien (although if the rationale was extended that far, we would probably have the Employment Development Department objecting to far more Compromises and Releases on the ground that the only method by which the Department could obtain reimbursement was directly from applicant).

In Crown Appliance v. WCAB, 69 CCC 55 (2004), the court held that Labor Code §5801 (providing for an award of attorney's fees in favor of applicant where a Petition for Writ of Review was found to have no reasonable basis) also applies as against an employer appealing from an

adverse decision in a Labor Code §132a action (the prior assumption being that it applied only in cases involving ordinary compensation). In Lett v. L.A.C.M.T.A., 69 250 (2004), it was held that applicant's entitlement to a Labor Code §5710 deposition fee was not dependent upon his client actually signing the deposition. The court noted that Code of Civil Procedure §2025(q)(1) provides that if the deponent refuses to sign the deposition, it is deemed signed anyway.

In Sav-A-Lot v. WCAB (Villanueva), 69 CCC 337 (2004), applicant declined to answer questions at trial regarding a video tape of her activities on the grounds that her answers might tend to incriminate her. The rule established by this case is that, while an applicant is entitled to claim the privilege against self-incrimination, the Board is entitled to draw an adverse inference from the refusal to the effect that the evidence, if given, would be adverse to applicant. In this case, the court held that the evidence as a whole was sufficient to overcome any adverse inferences, and it affirmed the award in applicant's favor.

In Messinese v. Automatic Heating, 69 CCC ______ (2004), it was held that an insurance carrier must comply with a child support wage assignment, whether the support obligation was incurred after the date of injury, or for arrears accrued prior to the date of injury, even where the order was not signed by a judicial officer. In this case, the judge had found that, to the extent that the order required the carrier to withhold for arrears, it was invalid as these represented pre-injury living expenses which could not be the subject of a lien. In reversing the judge, the Board found that the Family Code Sections dealing with wage assignments for child support obligations were exceptions to the general rule that the payment of workers' compensation is not subject to be taken by others than the applicant except by order of the Workers' Compensation Judge, and that temporary disability specifically falls within the definition of wages within the Family Code.

G. CONCLUSION:

SB899 has very substantially amended the Labor Code, and changed the manner in which workers' compensation will be practiced and administered in the future. As can be seen, there are a number of different interpretations with respect to these many significant Legislative changes, and no one really has any concrete or definite answers at this time, just best estimates.

Although the subject was touched upon briefly, it was our understanding going in to the convention that there probably would not be extensive general discussion with respect to the retroactivity of SB899. At least insofar as the Legislation purports to apply to injuries which occurred prior to its effective date (April 19, 2004), we anticipated there would be claims that retroactive application was an unconstitutional taking of property without due process of law as to vested rights created by the old rules regarding permanent disability and apportionment, and possibly even penalties (at least in connection with actions forming the basis of penalties which took place prior to the effective date of the statute). We had heard some suggestions that the problems of retroactivity were going to be handled quietly behind the scenes, and would not really be addressed at the general convention as CAAA as a whole did not really want to tip its hand with respect to what it was planning. At several times during the convention, the question of retroactivity was briefly addressed, and it was suggested that CAAA had determined that the retroactivity of SB899 was not subject to a constitutional challenge based upon the principles set forth in the Yoshioka v. Superior Court, 58 Cal. App. 4th 972 (retroactive application of the uninsured motorists statute provisions precluding non-economic damage recovery by an uninsured motorist), the rationale being that the retroactive provisions did not divest applicant's of vested rights, but simply changed the manner in which compensation was to be collected. The fact that this explanation was given with a bit of a

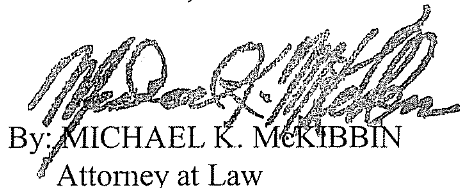
smile by Marc Marcus, Esquire, a first rate, aggressive, and politically active applicants' attorney who generally concedes nothing at all, certainly gives us cause to speculate that something is in the works. We suppose we will just have to wait and see what it is.

In the meantime, we work with what we have. To the extent that we perceive the amendments to be favorable to our position, we will use them. Only time will tell how they are eventually interpreted. It almost makes one look forward to the next convention.

If you have any questions or require any further information with respect to any of the subjects or issues contained in this report, or anything else for that matter, please feel free to give us a call. We will also be more than happy to prepare presentations with respect to the new Legislation, or any other subjects in which you may be interested, and if you are interested in this, please let us know. We appreciate the opportunity to bring you this report.

Very truly yours,

BENTHALE, NICHOLAS & McKIBBIN



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Attachment