BENTHALE, McKIBBIN & McKNIGHT

A Professional Law Corporation

1420 IOWA AVENUE. SUITE 230 • RIVERSIDE. CA 92507-0509 • (951) 300-2140 • FAX (951) 300-2130

THE DEFENSE PERSPECTIVE

AND OBSERVATIONS OF THE

CALIFORNIA APPLICANTS'

ATTORNEYS ASSOCIATION

SUMMER CONVENTION, 2005

LAS VEGAS, NEVADA

LOS ANGELES
900 Wilshire Blvd.. #805
Los Angeles. CA 90017-4701
(213) 427-7820

SANTA ANA
540 N. Golden Circle Dr. #305
Santa Ana, CA 92705-3914
(714) 972-8563

SACRAMENTO
2255 Watt Avenue. #165
Sacramento, CA 95825-0508
(916) 564-8977

OAKLAND
405 14th Street. #800
Oakland. CA 94612-2704
(510) 452-0636

TABLE OF CONTENTS

2005 SUMMER CONVENTION OF THE CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION

(June 23, 2005 - June 26, 2005)

TO OUR CLIENTS:

As is our practice, we have attended and are reporting on the events and happenings of the Summer, 2005 California Applicants' Attorneys Association Convention viewed, of course, through the jaundiced eye of defense counsel. Actually, the developments in workers' compensation law over the last few years have been very significant, and this time we are beginning to see the first of the important cases interpreting the effects of the SB 899 overhaul of the system that took place a year ago.

In contrast to the somewhat shrill and defiant attitudes which seemed to pervade the last two conventions, the leadership this time was noticeably more subdued. Significant cases with respect to apportionment and retroactivity have been decided, and the decisions were definitely adverse to the positions being taken by the Association. To a certain extent, one got the impression that they were "digging in" and now seriously exploring methods by which they could realistically deal with SB 899, since the recent interpretations appear to be confirming some of their worst fears.

That does not mean they are folding their tents. They feel they are being bullied by the defense and abandoned by what they once considered a friendly and solicitous Workers' Compensation Appeals Board in its rush to carry out what they perceive to be the new administration's policies. They stridently point out that Labor Code §3202, providing that the workers' compensation law should be liberally construed in favor of the injured worker, was untouched by SB 899, but in actual practice it is all but ignored.

Some, of course, are going to attempt to do business just as they have in the past. But, for the most part, there seems to be a new attitude. No where does this seem to be more apparent in connection with the proposals with respect to how to deal with the absolute two-year cap on temporary disability. The undersigned practically fell off his chair when he heard panelists advocating that they could no longer accept disability slips from doctors which indefinitely keep their clients out of work and that the most important focus with respect to temporary disability status should be getting their client's back to work as quickly as possible. Having been an applicant's attorney for a number of years through the mid-1980s, I leaned over to a defense colleague sitting next to me (who had also been an applicant's attorney in his deep, dark past) and whispered "What a concept! Back in the 1980s, I was telling my applicants that the best way to help their case was to get back to work as quickly as possible." My colleague looked at me and said, "That's why you're a defense attorney now--you had a bad attitude." Maybe I was actually just way ahead of my time.

In any event, it has now been determined that SB 899 is going to be affecting virtually every case which is presently pending. The question is whether the provisions of this comprehensive reform would be "retroactive" (this is a term of art; for the most part, the statute says it is prospective) applying to all pending cases, regardless of date of injury, from the date of it's enactment. This issue has been resoundingly resolved in favor of retroactivity, with the most

significant case in this regard being Kleemann v. Workers' Compensation Appeals Board, 70 CCC 133 (2005), which essentially held that procedural and substantive aspects of the new apportionment statutes apply to all cases which are pending as of the date of SB 899's enactment (April 19, 2004). This decision by the District Court of Appeals (a petition for hearing to the Supreme Court has been denied) effectively snuffed out the Board's En Banc decision in Scheftner v. Rio Linda School District, 69 CCC 1281 (2004) which took the perfectly ridiculous position that an Order Closing Discovery which issued prior to the enactment of SB 899 was an existing Order which could not be reopened under section 47 of SB 899 (a section which clearly, to everyone except the Board, applied to final adjudicatory type orders such as Awards).

It was certainly noted that SB 899 affects both procedural and substantive rights, but the Kleemann court noted that all of these rights were exclusively statutory, and held that the repeal of existing law which extends statutory rights normally ends all pending rights not yet vested in the absence of a savings clause (and there certainly was not one of those here). If those rights had not been vested by way of a final judgment (one not subject to further appeal), then the rights were not vested, and the urgency language in section 47 of the bill was interpreted to mean that the new rules apply in the absence of such a judgment.

With respect to some issues, SB 899 was quite clear. In Martinez v. California Building Systems, 70 CCC 202 (2005), the Workers' Compensation Appeals Board held that the repeal of the presumption of correctness of the treating physician applied to all cases without regard to the date of injury in the absence of a final decision based upon the presumption.

The Association is attempting to create some argument that there is actually a conflict between the Court of Appeals on the issue of retroactively based upon the penalty case, Green v. WCAB, 70 CCC 294 (2005), wherein it was stated that amended Labor Code §5814 actually

contained language making it retroactive, and since the Legislature did that with respect to this statute, it should be held that by not specifically making the bill retroactive elsewhere, those portions of SB 899 not specifically made retroactive (and they feel section 47 by using the word "prospective" is not an attempt to make the matter retroactive) should be held prospective with respect to injuries and/or conduct occurring only after the date of enactment. This is a hyper-technical reading of Green and, we feel, a misreading of it (much like the association flatly misread the new apportionment sections, interpreting them as in such a way as to argue that they either effected no change in the law with respect to apportionment, or made it even more favorable to applicants, something we now know is clearly not the case as we will be seeing below).

With this in mind, we turn to some of the more important matters of interest.

I.

APPORTIONMENT

As noted in the introduction, the issue with respect to whether SB 899's provisions with respect to apportionment are retroactive, has pretty much been decided by Kleemann v. WCAB, 70 CCC 133 (2005), as the Supreme Court has denied a hearing in this case (essentially, new Labor Code §4063 and §4064 apply to all cases in which there was no final, adjudicatory decision in existence prior to April 19, 2004). The Association suggests that the Court of Appeal's decision in Green v. WCAB, 70 CCC 294 (2005) creates a conflict within the Courts of Appeal (both of these decisions are out of the second district Court of Appeal), but this is a real stretch. The contention is based upon an argument that the amendment to Labor Code §5814 involving penalties contains specific retroactive language (something specifically noted by the Green court, and used as a basis for its decision), leading to an argument that, had the legislature intended the apportionment statute to be retroactive, they would have specifically said so. We do not see what happened here as a

conflict, however.

The statutory rules with respect to apportionment are now embodied in Labor Code §4063 and §4064. Labor Code §4063 provides that apportionment of permanent disability shall be based on causation and requires physicians preparing reports addressing the issue of permanent disability to also address the issue of causation of permanent disability, including an apportionment determination.

"A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of the injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries." Labor Code §4063(c)(emphasis added).

Labor Code §4063(c) goes on to state that if the physician cannot make an apportionment determination (and a determination includes an opinion that there is no apportionment), he must specifically state why he cannot make the determination, and is required to either consult with other physicians, or refer applicant to other physicians for the purpose of obtaining the determination.

Labor Code §4064 provides that the employer is only liable for the percentage of permanent disability directly caused by the industrial injury, and that if the 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 injury. This presumption is a presumption affecting the burden of proof". Labor Code §4064(b).

Of course, the problem here is the so-called "conclusive, rebutable presumption"; that's an oxymoron such an animal simply does not exist. Either a presumption is conclusive or it is rebuttable, it cannot be both. The Association tends to believe that, eventually, Labor Code §3202

(liberality in extending the protections of the workers' compensation law to injured workers) will compel an interpretation that the presumption, while perhaps a strong one, is actually rebuttable.

In the meantime, Association members are not beyond using Labor Code §4064 to their benefit. There is a Northern California trial level case (the identities of the parties have be redacted) which involves a prior Texas award of 14% with respect to the same body part. In the California case, applicant was limited to semi-sedentary work, and the evaluating physician felt that 50% of her overall disability was due to the Texas injury. Applicant's attorney argued, and the judge agreed, that Labor Code §4064 controlled, so the only thing that was apportioned was the amount of the prior Texas award (14%).

The prior rule with respect to apportionment required a showing that actual, permanent disability resulted from a prior disease or condition. So called asymptomatic pathology, or "retroactive prophylactic work restrictions" (a work limitation based upon a prior condition postulated after the industrial injury and made in the absence of evidence that the worker actually had been restricted in his or her work activities prior to the industrial injury) were not permitted. Statutorily, the apportionment rules were set forth in prior Labor Code §4063, §4750, and §4750.5 (relating to subsequent injuries). SB 899 substantially amended Labor Code §4063, added § 4064, and repealed Labor Code §4750 and §4750.5 altogether.

The defense community believed it was the Legislature's intent to work a significant change to the manner in which apportionment was determined. As we noted in our report with respect to the last two CAAA conventions, the Association was arguing that, despite the change in the language, the language could be interpreted in such a way that there really would not be much change (the statute still referred to the cause of "permanent disability", which the Association felt ruled out apportionment to prior, asymptomatic conditions), and, in fact, the Association believed that the

effect of SB 899 on apportionment could actually be interpreted favorably, arguing that the repeal of Labor Code §4750, in effect, also effectively eliminated the rule set forth in the hated case of Fuentes v. Workers' Compensation Appeals Board, 41 CCC 42 (1976), which created the subtraction method of apportionment. The reasoning here was that Fuentes was expressly based and dependent upon Labor Code §4750, and with §4750 gone, so was Fuentes. In fact, the Commission on Health& Safety in Workers' Compensation for the State of California in a memo dated December 4, 2004 suggested the Association might not be too far off base with respect to its opinions with respect to apportionment, noting it was conceivable that the courts could interpret "apportionment by causation" in the context of California's legal history (in which apportionment was clearly not favored). The Commission, however, did note it appeared clear that the legislative intent was to reduce the cost of workers' compensation, and to replace existing apportionment rules with something new.

It was exactly this observation that made by the En Banc Workers' Compensation Appeals Board in Escobedo v. Marshall's, 70 CCC 604 (2005). In this case, applicant fell, injuring her left knee, and as a consequence of that initial injury, began developing problems with her right knee as well. The award in this case was based upon the opinions of the defense qualified medical examiner, Daniel Ovadia, M.D., who is frequently used as an Agreed Medical Examiner. He felt applicant had an overall limitation which took an adjusted 53% rating, but also noted that applicant had obvious, significant degenerative arthritis in both knees, that the event in question was relatively trivial and he concluded that 50% of applicant's present disability was thus pre-existing, attributable to the degenerative arthritis. The trial judge agreed, an award of 27% issued, and the Workers' Compensation Appeals Board denied reconsideration. This may not be the end of the case, since a Petition for Writ of Review has been filed with the Court of Appeals and no action with respect to

it has yet been taken.

The Board felt, however, that the nature of the amendments to the apportionment statutes demonstrated a legislative intent to significantly change the law relating to apportionment, and that this was an intent to expand rather than narrow the scope of legally permissible apportionment. The Board defined causation as referring to causation of permanent disability, not causation of injury, and that the analysis of causal factors of permanent disability for purposes of apportionment may be different than causal factors of injury. The Board found that apportionment may include not only disability that could have been apportioned prior to SB 899, but could also include disability that formerly could not have been apportioned, such as pathology, asymptomatic prior conditions, and retroactive prophylactic work preclusions, provided there was substantial medical evidence establishing that these other factors have caused permanent disability.

The rule with respect to the character of medical evidence necessary remains in effect, that is, medical opinion must be framed in terms of reasonable medical probability, must not be speculative, must be based upon pertinent facts and on adequate examination and history, and must set forth reasoning in support of its conclusions.

In this case, Dr. Ovadia's analysis with respect to the effect of applicant's pre-existing arthritis might have almost been good enough to sustain an apportionment under the old law. He noted that the underlying, existing arthritis was obvious and significant, and essentially concluded that the events underlying the industrial injury would not have produced the type of disability found here in the absence of a progressive, underlying condition (even though applicant denied prior problems with her knees).

The Board held that applicant has the burden of establishing the percentage of permanent disability directly caused by the industrial injury, and the burden of establishing the approximate

percentage of permanent disability directly caused by the industrial injury. Quite frankly, this might not be entirely accurate, since it seems to overlap what is admittedly the defendant's burden: establishing the approximate percentage of permanent disability caused by factors other than the industrial injury. We think that, to carry defendant's burden, a physician is going to need to look at three things:

1. The underlying pathology or condition in connection with which apportionment is claimed. To a certain extent, if we are talking about pathology, we tend to think it is going to have to be significant enough where a reasonable assumption can be made that it is progressive.
2. The mechanism of injury itself. Are we talking about a relatively minor event (from which you would not expect substantial permanent disability), or are we talking about catastrophic trauma (if a person falls 50 feet from a scaffold, we do not think a little bit of pre-existing arthritis is going to be of much help).
3. Applicant's past medical history (the complete absence of a medical history with respect to the pre-existing pathology or condition is going to be problematic, and will lend itself to an argument by applicant that an apportionment determination is speculative). To a certain extent, that is the Association's position in these cases in light of Escobedo: take the deposition of pretty much every doctor where the determination is made, as they feel most doctors, when pressed, will admit that apportionment based upon pre-existing, pretty much asymptomatic pathology, is the result of educated guess work, or speculation.

Needless to say, the Association is completely frustrated with Escobedo. At this point, the Association is conceding that Labor Code §4063 and §4064 did ease the defendant's burden with respect to proving apportionment, but feels what Escobedo allows is completely wrong. The Association is arguing that Escobedo's reasoning is actually in conflict with AMA Guidelines (which

the Association does not like either), as Chapters 1 and 2 of the AMA Guides indicate that an impairment rating cannot be imposed with respect to asymptomatic pathology.

There is also the issue with respect to the concept of both "lighting up" of a previously asymptomatic underlying pathology (an exacerbation or acceleration of an underlying condition by an industrial injury). Escobedo specifically noted that there was no claim of "lighting up" in the present case (although we are not quite sure how, to a certain extent, there could not be).

What the Association is desperately looking for at this time is a "test case", the preferred examples being that of a diabetic who sustains a toe injury, which, because of the diabetes, becomes infected and results in an amputation, or a case of a worker with markedly advance osteoporosis, whose vertebrae disintegrates when he twists to reach for a pencil at his desk. From a defense standpoint, these are "bad facts make bad law" type cases; the Association feels that the injured worker's situation is desperate enough that it will engender sympathy, and will thus cause the apportionment rules to be interpreted much more narrowly.

A critical issue which may have in part been resolved is the issue with respect to how apportionment is to be calculated, with a very recent pronouncement being Nabors v. Peidmont Lumber & Mill Company, 70 CCC _____ (2005) , an En Banc Workers' Compensation Appeals Board decision holding that the subtraction method set forth in the Supreme Court's decision in Fuentes v. Workers' Compensation Appeals Board, 41 CCC 42 (1976) was still the appropriate method of calculating apportionment. This case is also presently the subject of a recently filed and pending Petition for Writ of Review, but Nabors rejected Association's contention that the repeal of Labor Code §4750 had the effect of vacating the Fuentes decision, holding that Fuentes' rationale was still good law.

However, Nabors is problematic and, if upheld, may be limited to the particular situation to

which it applied. In Nabors, applicant sustained an industrial back injury on August 19, 2002, and had overall permanent disability of 80%. However, he also had a prior industrial back injury for which he had received a 49% award, so, pursuant to Labor Code §4064, the judge apportioned this away, giving applicant a net award of 31%.

Actually, given the facts of this case, this appears to be a perfectly appropriate result, since both disability ratings were based upon the permanent disability schedule in effect prior to January 1, 2005 (and, thus, the method for calculating the permanent disability with respect to the 2002 industrial injury, and the prior injury which was the subject to the 49% award, were identical).

The real problem occurs in connection with an attempt to apportion a prior disability award from an impairment based rating under the AMA schedule in effect commencing January 1, 2005. It is becoming clear (actually, it's been clear for some time; the recent ratings which we are now seeing based upon the AMA schedule are simply confirming what we have known) that impairment based disability rated on the AMA schedule are significantly less than the same disabilities would have rated on the old permanent disability schedule (the undersigned is handling a knee case which would have rated 35% under the old schedule, but under the AMA Guides rates 5%; applicant attorneys are claiming reductions in the 40% to 80% range, and this is probably not too far off the mark).

So, back to my knee case, how do I apportion this gentleman's prior 30% award when his present impairment rating is 5% (under the old work restriction method, the net result after a Labor Code §4064 apportionment would be 5%). Does he owe us money?

Quite frankly, Nabors just does not work in this situation. But the argument being made by the more stringent voices of the Association (you cannot apportion apples from oranges, so there is no apportionment at all) is not workable either (as it is entirely inconsistent with the terms of the

statute; in fact, the association favored method of apportionment, as annunciated in Nabors, is not even workable: their argument is that the monetary value of the former award should be deducted, rather than the percentage value. In my knee case, the applicant still owes us money).

The problem is that nobody seems to want to consider a middle road, although there are at least some voices (somewhat lost in the din) which suggested that Labor Code §4064 apportionment could be accomplished on a proportional basis, i.e., in addition to the AMA impairment determination, the doctor would also have to perform an analysis of what applicant's disability would have been under the prior disability schedule. The prior award could then be compared to this disability, and a proportional determination reached. (In my knee case, this would result in about an 88% apportionment to the prior disability).

Extreme positions are probably not helpful on either side. Thus we have Reyes v. Workers' Compensation Appeals Board, 70 CCC 223 (2005), which really tells us nothing new, but appears to be the result of an attempt to take the new apportionment statutes to the absolute limit on the defense end of the spectrum. In this case, applicant was on a scaffold, suffered a seizure, fell off the scaffold, and free fell 50 feet to the ground. Everyone agrees that the seizure was non-industrial, the defense argument being that since the seizure caused the fall, causation was entirely non-industrial, and there is no industrial injury. This forgets, of course, that the real cause of the fall was that applicant was working on a scaffold 50 feet off the ground and, if he has a seizure while he is at home, he probably does not break every bone in his body. What Reyes essentially says is that apportionment is not a good injury AOE/COE defense (just as apportionment does not apply to issues of temporary disability or medical treatment). Apportionment is a defense only with respect to permanent disability.

II.

TEMPORARY DISABILITY LIMITATIONS

The basic statute here is Labor Code §4656(c), in essence providing a temporary disability cap of "104 compensable weeks within a period of two years from the date of commencement of temporary disability payment." (With certain exceptions for specified types of injuries, in which the maximum aggregate would be 240 compensable weeks within a 5-year period.

Everyone seems to be in agreement that the period upon which the cap is based begins with the commencement of temporary disability payments (as opposed to the date of injury), so if the commencement of temporary disability can be deferred for a period of time, conceivably, applicant can stay out of work longer. Thus, there are suggestions that applicants first utilize accrued vacation and sick time, and perhaps long and short term disability payments.

There are also suggestions that applicants immediately apply for Social Security disability benefits, and state disability benefits, although neither of these benefits are going to provide an applicant with short term relief in terms of allowing a deferral of temporary disability. In connection with state disability benefits, the Employment Development Department will not pay those benefits if the workers' compensation carrier is willing to pay temporary disability. The idea with respect to the state disability application, however, is to lock in the rate, since state disability establishes its rate by reference to the last three quarters of earnings. Thus, the theory is that, even though the state disability application is initially denied because of the payment of temporary disability, after the two year cap has expired, an applicant can reapply, and receive the rate which was locked in at the time of the initial application.

The receipt of such benefits is going to problematic for an applicant, however, since the workers' compensation carrier is certainly not going to be responsible for temporary disability

benefits after the expiration of the cap, with the result being that the Employment Development Department will have a lien against applicant's permanent disability (and any applicant who receives a year of state disability benefits is going to be looking at a substantial deduction in permanent disability, particularly permanent disability based upon the AMA Guides.

From applicant attorney's standpoint, the temporary disability cap actually dovetails (and from an applicant's perspective, complicates the situation arising from) the elimination of rehabilitation. The only thing left in connection with rehabilitation is the supplemental job displacement voucher described in Labor Code §4658.5 (there is the potential of 15% adjustments to the permanent disability rate pursuant to Labor Code §4658[d] as well). From the applicant's perspective, this has resulted in a change of attitude with respect to the job on which an applicant was injured: applicant attorneys point out the irony of the fact that for many years applicants expended substantial effort in resisting a return to their prior employment, and in insisting upon full rehabilitation benefits, which included prolonged training programs, etc.; after the rehabilitation cap was imposed, suddenly many employers began seeing rehabilitation as a relatively inexpensive way of ridding themselves of problematic employees, particularly those who might require special treatment and/or accommodations if they returned.

The new emphasis here, according to the panelists, is returning the applicant to work as quickly as possible, and informing their doctors that these are the new marching orders (from the Syllabus: "We cannot accept a disability slip from a doctor with a 'totally temporary disabled' checkmark, without any specific restrictions listed. These kinds of reports do nothing to help the employee return to his or her job." What a perfectly remarkable change in attitude.

Again from this syllabus: "If the employee is still temporarily disabled after 104 weeks, we cannot allow a finding by the doctor that will allow the employer to say that the employee is

permanently disabled from doing his or her job."

So if applicant's doctors have been doing and saying these same things for years and years, what advances in medical science suddenly allow them, under identical factual situations, to recommend something completely different? Sometimes, it is extremely difficult not to be cynical.

The bottom line, however, is that there is going to be a refocus on the part of the applicant's side, the objective of which is to return workers' to their pre-injury employment. Physicians will be encouraged to allow a return to modified work during the recovery period, and demands will be made of employers to provide accommodations. These will be backed up by threatened actions under Labor Code §132a, the ADA, and FEHA, and in connection with these latter statutory actions, the employer would be defending itself in Federal or State court, rather than the Workers' Compensation Appeals Board.

We have seen many Notices of Potential Eligibility where the employer simply advises the carrier that they have no work available within the proposed restrictions, but we foresee applicant attorneys demanding much more detailed explanations with respect to what efforts were actually made to find an accommodation. An example of the type of situation an employer might be facing was the FEHA case of Jensen v. Wells Fargo Bank, 85 CA 4th 245 (2000), where it was indicated that a disabled plaintiff establishes a prima facie case against his or her employer by proving that plaintiff suffers from a disability, plaintiff is a qualified individual, and plaintiff was subjected to an adverse employment action because of the disability. In this case, plaintiff, a branch manager for a bank, was the victim of an attempted bank robbery, after which she was diagnosed with post-traumatic stress disorder, which essentially precluded her from working with the public or with money. The bank apparently proposed several alternative positions, all of which were unacceptable to applicant (she refused to work in a position which required visiting branch offices, performing

sales jobs, working in certain geographical areas, working in a non-office environment, taking a job for less than what she was previously earning, or accepting a temporary position). Quite frankly, our initial reaction was that this would open applicant up to a charge that she was being uncooperative, and perhaps that defense would be available in front of a jury, but it was not enough to allow the employer to escape pursuant to a Summary Judgment motion. It was held that evidence was required with respect to not only the severity of applicant's psychiatric disorder, but also whether the bank's actions in failing to accommodate applicant with respect to several positions which she indicated had been available (but were apparently given to allegedly more qualified applicants) was reasonable. This could be a very expensive proposition for an employer.

In Barns v. WCAB, 54 CCC 433 (1989), applicant sustained an industrial injury, and was eventually terminated after an attempted return to work where he sustained a re-injury. The employer claimed that since applicant could not be medically cleared to return to his former employment, he was terminated since the employer did not want to risk re-injury but, in terms of an accommodation, the employer claimed it had a policy which precluded an injured employee from seeking a new position until he or she was able to return to the one occupied before the injury. This was found to be a violation of Labor Code §132a.

There is a fine line here, and we think it is very possible the line will be crossed in applicant's favor. Where an applicant had alleged a Labor Code §132a violation based upon a failure of an employer to accommodate, we have defended those cases on the basis the statute prohibited discrimination, but did not require the affirmative act of accommodation. Barns seems to be very close to suggesting that, in order to avoid discrimination, at least under some circumstances, the employer may be required to provide accommodation. With the end of rehabilitation, we may well be seeing an expansion in this direction.

III.

MEDICAL/LEGAL ISSUES RELATING TO THE PRODUCTION OF EVIDENCE

The primary statutes relating to medical/legal procedures (essentially, the production of medical evidence for the purpose of proving or disproving a claim), are found in Labor Code §4060 (injury AOE/COE issues); §4061 (determinations with respect to the extent of permanent disability); and §4062 (determinations of issues other than those governed by Labor Code §§4060 and 4061). The specific procedural methods by which these statutes are to be implemented are set forth in Labor Code §4062.1 (where applicants are unrepresented), or §4062.2 (where applicants are represented). Labor Code §4062.1, relating to unrepresented applicants, really did not change much in terms of the procedure for obtaining medical/legal evaluations (the Administrative Director, on request, sends applicant a panel of three qualified medical examiners, and applicant can choose an examiner. The only change comes in the event that applicant does not make the choice within 10 days of the assignment of the panel, the employer is now specifically authorized to make the choice for him pursuant to §4062.1[c]).

The problem with Labor Code §4062.2, relating to represented cases, is that it was date specific, stating that it applied to injuries occurring on or after January 1, 2005. A number of applicant attorneys made the argument that this left the parties without the ability to obtain a qualified medical examination in connection with any injury occurring prior to January 1, 2005, after the effective date of SB 899 (certainly an advantage for an applicant's attorney who had a hand-picked free-choice doctor in place). This claim led to Simi v. Sav-Max Foods, Inc., 70 CCC 217 (2005), an En Banc Workers' Compensation Appeals Board decision which essentially applied the "ghost statute" reasoning of Godinez, 69 CCC 1311, finding that the old and now non-existent former Labor Code §4060, §4061, and §4062 applied to injuries occurring prior to January 1, 2005

(a legal fiction if you will).

The Association's official take with respect to Simi is that it is wrong, but everyone could live with it. Actually, Simi appears to be completely wrong, and in reality misinterpreted the true nature of Labor Code §§4060-4062. Prior to their first appearance (requiring the parties to participate in what has become known as the "AME/QME dance"), there was no regulation on the right of the parties to obtain medical/legal evaluations. If a party needed a medical/legal evaluation, the party went out and got one. The effect of Labor Code §§4061 and 4062 was to limit the right of the party to obtain a medical/legal evaluation, requiring certain conditions precedent to the right of a party to obtain such an evaluation (a specific objection to a particular medical event and, in the case of Labor Code §4062, the objection had to be made within a specific time period), and then an attempt to agree on an Agreed Medical Examiner. Only after these conditions had been met, could a party then obtain a medical/legal evaluation through a state-designated qualified medical examiner (these qualified medical examiners did not exist prior to 1991, when the statutes became effective).

What really happened on the effective date of SB 899 is that these limitations on the right of a party to obtain a medical/legal evaluation in connection with a pre-January 1, 2005 injury, were eliminated, and the parties should have been able to revert to the methods of obtaining medical/legal evaluations as they existed prior to 1991. This point seems to have been missed by pretty much everyone, so we are now stuck with the legal fiction but, as panelist Ronald Feenberg remarked, "We can live with it".

As an aside, there are actually some rather serious inconsistencies between the newly-amended Labor Code §§4060-4062 (providing in effect, that the only method of obtaining medical/legal evaluations is through the procedure set forth in Labor Code §4062.1 and/or §4062.2) and Labor Code §4064, which provides that no party is prohibited from obtaining any medical/legal

evaluation or consultation at its own expense, and that all comprehensive medical evaluations obtained by any party shall be admissible (except for specified statutory exceptions, which either do not apply or no longer exist. This is not the only inconsistency in this group of statutes, but the problem is that a number of the statutes subsequent to Labor Code §4062.2 have been left essentially untouched since becoming effective as a part of the several reform packages which have come along in the 1990s and early in this century).

We now know that, in represented cases, where the parties are unable to agree upon an Agreed Medical Examiner, upon request the Administrative Director is supposed to send out a panel of three qualified medical examiners (we are not sure what the Administrative Director does in terms of the composition of the panel if there is a dispute with respect to the specialty of the physician required).

Once it is again determined that no agreement can be reached and then names are stricken, leaving a designated qualified medical examiner, then Labor Code §4062.3 governs what information may be sent. Apparently, if it is medical information, it can all be sent (although the opposing party must be given 20 days notice of what is being sent). However, a party may object to providing non-medical information to the examiner and, if an objection is made, the information does not get sent.

What if the information is deemed crucial? The statue does not address how this dispute is to be resolved, but we suspect that there are two ways: File a DOR on the discovery issue, or set the examiner's deposition, and bring the information to his attention by way of hypothetical questions (in this way, he does not really see the information, but he is asked a series of "what if" questions based upon the assumption that the information being represented is accurate).

Applicant attorneys were also encouraged to use the treating doctor as a discovery tool, since

the treating physician can be accorded the same weight as a panel-selected QME. In fact, it is suggested that applicants might actually have an advantage in at least setting up treatment evidence for the use of a subsequent qualified medical examiner through the use of Labor Code §4601, which provides in part: "the employee is entitled, in any serious case, upon request, to the services of a consulting physician, chiropractor, or acupuncturist of his or her choice at the expense of the employer. The treatment shall be at the expense of the employer."

This section remained unmolested by SB 899, and even in the case where an applicant is treating within a medical provider network, gives an applicant the opportunity to obtain a consulting treatment opinion outside of the network. The report is certainly admissible under Labor Code §5703, which provides that the reports of treating doctors are always admissible (and this physician would certainly be classified as a consulting treating doctor).

It turns out that a "serious case" is not what we might initially think since the term is actually defined in both Labor Code §4616.2(d)(2)(B) (a medical condition that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration) and 8 CCC Reg. §9767.9(e)(2) (a medical condition that is serious in nature and that persists without full cure or worsens over 90 days and requires ongoing treatment to maintain remission or prevent deterioration). Basically, what we are looking at is the ACOEM definition of a chronic condition, i.e., the Association is saying that any medical condition which progresses from the acute to the chronic stage can be deemed a serious medical condition entitling applicant to a consulting physician under Labor Code §4601. Some of the panelists took the position that a Labor Code §4601 consultation should not be used as a serepetitious qualified medical examination, but it is clear that the procedure was being proposed for just that.

We suspect that if there is an entitlement to such a consult under Labor Code §4601, the most effective way of combating the opinions of this consult is also through the treating physician, who is required to incorporate and comment upon the opinions of secondary and/or consulting treaters. Send the treating physician the consultant's report, and ask him to comment and critique it. Given the limited control the parties have over the panels to be selected by the Administrative Director, it does appear that a lot of the medical/legal maneuvering may be taking place prior to the actual medical/legal evaluation.

One final note, the panelists observed that one Association member (nameless to protect the guilty) attempted to challenge a utilization review recommendation by scheduling the deposition of the utilization review doctor. Eventually, that subpena was quashed, the result being that the judge found the appropriate method of challenging a utilization review decision was through the procedures set forth in Labor Code §4062.

IV.

WORKING WITH THE AMA GUIDES IN THE DETERMINATION OF PERMANENT DISABILITY

As distraught the applicant's side of the bar is with respect to the Escobedo decision on apportionment, they are equally, if not more, distraught over the effect that the AMA impairment schedule is having on the level of permanent disability. As noted previously, depending upon the injury, reductions from what was allowed by the prior schedule of up to 70+ percent are being claimed.

We are told that the purpose of the AMA Guides is to provide a standardized, reproducible and objective approach to evaluating medical impairments, with an impairment being defined as the loss of use or derangement of a body part or organ system. The Guides indicate that an impairment

rating does not measure disability or the loss of work capacity, but rather is related to functional limitations or the ability to perform the everyday activities of daily living. The AMA Guides have actually been adopted by most states for the purpose of providing an evidence based system to assess impairment in connection with work injuries, and are also used in Longshore cases and Federal workers' compensation. It is noted that impairments can be under reported, if appropriate weight is not given to applicant's ability to perform activities of daily living. In California, certain disabilities are conclusively presumed to be total, and it is noted that the schedule provides that the Guides themselves are only presumptively correct. Based upon the strict application of the Guides, a person will be considered totally disabled only after he is dead.

Thus, the ideas is being advanced at this convention are methods by which the "presumptively correct" Guides could be rebutted. Although there are bitter complaints about the unfairness of the Guides in recommending what are considered to be inadequate impairment ratings, from the Convention's standpoint, the most promising challenge appears to be to the so-called future earning capacity (FEC) variant, which was supposed to be determined based upon a "numeric formula based upon empirical data and findings that aggregate the average percentage of long-term loss of income resulting from each type of injury for similarly situated employees." Labor Code §4660(b)(2), in combination with the additional admonition that permanent disability shall take account of the employee's diminished earning capacity. Labor Code §4660(a).

The Association's position is that the numerical ranks (1-8) for future earning capacity set forth in the new AMA schedule are completely arbitrary, and in no way based upon "empirical data and findings that aggregate the average percentage of long-term loss of income". Their idea with respect to specific cases is to quantify pre-injury earning capacity, and what is available to an employee now (particularly if an employee is unable to return to his previous employment, either as

the result of disability or lack of accommodation), and to evaluate this in light of a person's physical and educational characteristics. Actually, on its face, this approach, from the applicant's standpoint, may appear to be the most promising method circumventing impairment ratings. The Guides themselves state that cases can be complicated where "the physician is requested to make a broad judgment regarding an individual's ability to return to any job in his/her field. A decision of this scope usually requires input from medical and non-medical experts, such as vocational specialists, and the evaluation of both stable and changing factors, such as the person's education, skills, and motivation, the state of the job market, and local economic considerations." (AMA Guides, page 14). Thus, the Association encourages its members to ask physicians to describe an applicant's functional capacity limitations, noting that chapters one and two of the AMA Guides indicate that a doctor is to describe an applicant's functional capacity limitations, and can in fact state a work restriction, if that is deemed necessary. The idea here is also to encourage the physician to acknowledge that he/she has no expertise in vocational matters, and that a vocational specialist should be consulted (thus laying the foundation for the obtaining of such an expert).

Page 23 of the AMA Guides expressly permits a physician to deviate from the Guidelines if the physician finds that it is necessary to produce an impairment rating more accurate than the recommended formula can achieve, and page 11 of the Guides also indicates that where impairment ratings are not provided, it is suggested the physicians use clinical judgment, utilizing comparisons.

From all of this, utilizing the vocational expert and the evaluating physicians, the Association thinks that, at least in appropriate cases (the members are encouraged to be somewhat judicious with respect to the circumstances under which this approach is used, and it is very much like a LeBeouf approach), it is possible to develop a loss of future earning capacity determination which is specific to an applicant's particular situation. Our question, of course, is where does the impairment rating

itself fit in to this, since establishing the impairment rating, at least according to Labor Code §4660(a) appears to be a pre-requisite to determination of future earning capacity (at least we would argue this). In other words, the Administrative Director's 8 variants tell us how to modify the raw impairment rating for the purpose of reaching a standard rating; how do we do this if we have an individualized diminished future earning capacity determination? The Association's approach seems to be that, if an individualized diminished earning capacity determination can be made, that, in effect, does away with the raw impairment rating entirely, and it is the percentage derived from the loss of future earning capacity that is actually used (in other words, if an applicant has a 60% loss of future earning capacity, that, in fact, would be the standard rating).

To a certain extent, we do not think that such a radical departure from what is allowed by the raw impairment ratings would actually be permitted on a widespread basis although, like LeBeouf type cases, and, because of the relatively low levels of disability permitted by the use of impairment ratings, perhaps even quite a bit more often, we see this alternative as perhaps being viable.

Who will pay for the vocational expert? Assuming it is determined to be necessary in a particular case (and by necessary, we do not think it is necessary that an applicant actually prevail; we think an applicant need only show that the expense was necessary to make a reasonable argument), we think defendants will be responsible for the cost on a medical/legal basis. In this regard, the Association cites Johnson v. WCAB, 49 CCC 716, indicating that even the provisions of Labor Code §5811, relating to the responsibility for payment of expert witness fees, must be construed liberally for the purpose of extending benefits to those injured in the course of employment.

It would appear that all those vocational rehabilitation vendors we thought were out of work may be finding new life.

V.

MEDICAL TREATMENT AND CONTROL

Even though there is no presumption of liability, we all know that Labor Code §5402(c) now requires that, at least until a case is denied, an employer, within one day of the report of an injury, provide medical care and continue providing it up to a maximum ceiling of $10,000.00. If the case is denied, or if the employer refused to provide medical care, the Association claims that applicant has a right to free-choice a physician (presumably on a lien), and the Association is probably correct on this point. Defendant's liability will eventually depend upon whether industrial injury is found, although we suspect that the first $10,000.00 of care (or at least the value of care up to the date of denial) will be defendant's responsibility, regardless of whether injury AOE/COE is found.

This section will be devoted primarily to those cases where injury is accepted, and defendants now have two primary tools with which to work: Statutorily authorized utilization review, and control of medical treatment through medical provider networks. Starting with the networks, there is certainly a difference in approach between Northern California applicant attorneys and Southern California applicant attorneys. To a certain extent, Northern California attorneys appear to be more willing to try to work with the networks; there are, however, a number of Southern California attorneys who take the approach that they will break from the networks and self-procure their own doctor (on a lien, if necessary) at every conceivable opportunity. Thus, situations in which it is advocated that an applicant may escape control of the medical provider network are when medical care is not offered or provided by the employer after the report of injury (the contention being that the employer must make an active effort to provide medical care); despite the existence of a MPN, medical care was not provided within three working days as provided by Labor Code §4600, §4616.3; the employer does not have an MPN (free choices permitted after 30 days); applicant has

been released by a non-MPN physician with a recommendation for further medical care (pursuant to Regulation §9785, as amended in June, 2004); independent medical review (through the Administrative Director) finds that disputed treatment or diagnostic testing is proper; refusal to allow changes of treating physician within the MPN; lack of geographic convenience for physicians within the MPN; medical treatment not timely provided; where applicant has a present free-choice physician, arguing the exceptions to MPN control to maintain control. Those statutory escapes relate to the treatment of an acute condition (30-day transition); a serious chronic condition (we previously saw the definitions of this, and a transition of up to one year is allowed); a terminal illness (until the condition ends, essentially a death); or performance of surgery (through appropriate follow-up).

The next major issue relates to utilization review, about which there seems to be a great deal of confusion by all concerned. From the defense side, by virtue of the authorizing statutes, we tend to view utilization review reports as being presumptively correct. That is not correct. The statute provides that the Guidelines (either ACOEM, or, whenever the Administrative Director gets around to it, the Administrative Director's Guidelines) are presumed correct, not the utilization reviews based upon those guidelines.

On the other side of the fence, applicant attorney's appear to assume that every utilization review is based upon the ACOEM Guidelines, and, while many of them are, many are also based upon what is considered to be just good medical practice.

The problem with ACOEM is that, by its own terms, it does not apply to chronic conditions (under the regulation cited in the chief previous section, and under the guidelines themselves, this is any condition which persists for more than 90 days). In Hamilton v. State Compensation Insurance Fund, 32 CWCR 249 (2004), the Board found that a utilization review based upon ACOEM Guidelines (with respect to the awarding of a gym membership) was inappropriate, since

the ACOEM Guidelines only apply during the first 90 days following industrial injury. This is going to be a continuing issue, unfortunately, until the Administrative Director adopts a permanent utilization schedule (it should have been adopted months ago, and there is no indication when it will finally be in place).

Probably one of the most common pitfalls for utilization review relates to timeliness, in general Labor Code §4610 providing between 5 and 14 days (depending upon when the employer has appropriate information) in most cases, or within 72 hours when there is an urgency. In Sandhagen v. Cox & Cox Construction, 69 CCC 1452 (2004) it was held (an En Banc decision) that if utilization review was untimely, utilization review reports were inadmissible for any purpose, including submission to medical examiners. This essentially leaves a defendant defenseless against a proposed treatment decision, if utilization review was done untimely (on the other hand, if utilization review is properly done, and a recommended course of treatment not certified, the treating physician cannot ignore it; he must attempt to explain why it is the utilization review is incorrect). Smith v. Churn Creek Construction Company, 69 CCC 1012 (2004).

Things become a little confusing, however, where there is a valid decertification in the case of concurrent ongoing medical treatment. Under those circumstances, Labor Code §4610(g)(3)(B) requires that an alternate care plan be developed, with the agreement of the treating physician, to meet the needs of the applicant. Suppose the treating physician does not want to agree? Under the circumstances, if the care is not radical or intrusive, perhaps the best course of action is to simply maintain the status quo (keeping in mind the absolute statutory limitations on physical therapy, chiropractic treatment and/or occupational therapy set forth in Labor Code §4604.5) pending determination of the treatment issue by way of Labor Code §4062.

A primary weapon which is probably going to be used by many applicant attorneys, however,

is the paper war. Association members have been provided with sample letters objecting to utilization review determinations, and objecting to medical provider network referrals. Appended to this report as Attachment "1" are three such letters from one of the more aggressive law firms in the area and, unfortunately, most of what they request is supposed to be a part of the public record, and is probably producible. What we suggest is that our clients simply put a package together which responds to all of these demands, so that there is no scramble to attempt to obtain the individual documents at the time the demand is received.

VI.

CIRCUMVENTING STATUTORY LIMITATIONS

Initially, this game started with the adoption of SB228 and AB227, effective January 1, 2004, particularly Labor Code §4604.5's restrictions on chiropractic/physical therapy visits (allege multiple injuries, so as to multiply the number of caps). The idea is gaining momentum with the temporary disability limitations, and the implementation of the AMA schedule. In connection with the temporary disability cap, certainly the most obvious escape is the attempt to combine pre-SB899 injuries with current injuries. Temporary disability is not apportionable, so if any of the prior injuries are responsible for applicant's ongoing temporary disability, then the Labor Code §4656 cap does not apply.

There is actually a rather interesting discussion of utilizing Escobedo v. WCAB, 70 CCC 604 (2005) in connection with this discussion of a causation, and relation of underlying conditions to overall disability. In other words, even if a pre-existing, non-industrial condition or pathology would not result in industrial permanent disability, there is a suggestion that an argument can be made that the primary industrial injury in some manner aggravated or exacerbated the non-industrial condition, providing a need for additional temporary disability, and/or medical treatment, and treating that

aggravation or exacerbation as a separate injury. However, this is more of a consequential type injury which we think would actually relate back to the date of original injury, and would not serve that purpose.

To a certain extent, we think that the date of injury is actually going to be defined by the date of the incident itself. As creative as it sounded, we doubt that the skin and contents type claim can actually serve to expand the temporary disability cap, since everything is going to eventually relate to a particular event. It was noted that a cumulative trauma is defined as a series of microtraumas, so a suggestion was made that consideration be given to pleading a series of specific traumas (rather than an overall CT), since the Labor Code §4656 temporary disability cap is injury specific, that is, the cap applies to each injury; if you have more than one injury, you will have multiple caps.

On the other hand, the statute also contains a time limitation (two years from the commencement of temporary disability). So if two injuries concurrently cause the commencement of temporary disability, we actually think that the two-year limitation with respect to both injuries will be measured from that particular date.

Probably the most promising method of maximizing disability money from an applicant's perspective is the addition of psychiatric claims (and we expect to see a proliferation of these). Under the new AMA schedule, psychiatric claims are rated more liberally than any other type of injury, although the raw rating is obtained by reference to the global assessment of functioning scale (ranging from 1, a person in persistent danger of severely hurting oneself or others, and a persistent inability to maintain personal hygiene), to 100 (superior functioning in a wide range of activities). Under this scale, it is noted that an individual may have legitimate, residual mild psychiatric symptoms, and but still function well in their employment setting, and under these circumstances, would not be ratable (and, perhaps that is as it should be).

The most frequent use of the psychiatric claim will probably be as a consequential injury to an admitted physical injury (and the more serious physical injury, the more likely a legitimate psychiatric consequential claim).

Perhaps as complicated as the apportionment issue as between injuries rated under the prior present permanent disability schedules, is the continued viability of Wilkinson v. WCAB, 42 CCC 406 (1977), standing essentially for the proposition that, where there are successive injuries to the same parts of the body, and those injuries become permanent & stationary at the same time, they should be combined for rating purposes. The Association viewed Wilkinson as being an outgrowth of Fuentes v. WCAB, 41 CCC 42 (1976), which established apportionment by the subtraction method. The Association thought that, to the extent that Fuentes might no longer be good law (based upon the repeal of Labor Code §4750 upon which it was based), Wilkinson may have gone with it. The reason for this is based upon the method by which the Association has always advocated that apportionment should be done: by subtraction of the money received in connection with the prior injury, rather than buy subtraction of the percentage of disability, which is essentially what is accomplished by Wilkinson). We suspect that, in light of Nabors referenced previously, Wilkinson is certainly deemed alive, although how it will be applied with respect to injuries rated under the old schedule and subsequent injuries rated under the new schedule is certainly going to be a major issue.

VII.

ISSUES RELATING TO PUBLIC SAFETY EMPLOYEES

Defending cases involving public safety employees involve a whole set of special considerations. First, there are the various rebutable presumptions with respect to the industrial nature of certain injuries (Labor Code §3212 through §3213.2), the specific types of injury being (depending upon the nature of the occupation, but relating to police officers and firefighters, in

general) cancer, the heart, certain blood infections, tuberculosis, meningitis, skin cancer, lyme disease, and the low back (hypertension by itself is not deemed to be heart disease, although the definition of heart disease is rather broad). After termination applicant is given, generally, three months for every year of service, up to 60 months, for which the disease to manifest itself. If the presumption applies, in many of the cases relating to the heart, hernia, pneumonia, or blood bourne disease, no apportionment to pre-existing conditions is permitted (and this specific statutory direction would probably trump the general apportionment rule set forth in Labor Code §4663).

These presumptions of injury are rebuttable, but the burden on defendant would appear almost impossible. In Faust v. City of San Diego, 68 CCC 1822 (2003) that burden was defined as requiring defendant (in a cancer case) as establishing the primary site of the cancer, and establishing that there was no reasonable link between the carcinogen to which applicant was exposed and his resulting cancer. (We suspect one defense would be to show that an applicant was not exposed to any carcinogens). In City of Long Beach v. WCAB, 70 CCC 109 (2005), an agreed medical examiner found applicant's kidney cancer to be non-industrial, since there were no medical studies showing a link between kidney cancer and benzene (the exposure here was applicant's pumping gas into his vehicle on a daily basis, which would have exposed him to benzene in the gasoline). The agreed medical examiner's opinion was rejected, the cancer was found to be industrial, and the court held that it was the employer's burden to establish the absence of scientific knowledge, and that the mere showing that there is an absence of medical studies to show a reasonable link, is not enough. In other words, Dr. O'Neill's opinion that there were no scientific studies actually favored applicant; defendant had the burden to show that there were scientific studies, and that the scientific studies showed that there was no link between the type of cancer applicant had, and the carcinogen to which he was exposed.

Temporary disability rules for public safety officers are somewhat different as well, governed by Labor Code §4850 (in shorthand, known as §4850 pay). This statute requires that certain public safety officers be paid their full salary for up to one year after injury (and this one year aggregate is not limited to an unbroken period of absence). An Attorney General's opinion (#68-1, April 4, 1968) determined that, while similar to temporary total disability in some respects, Labor Code §4850 pay was a special benefit which was not subject to the general time limitations of temporary disability, and was, therefore, payable from the first day of absence (in other words, no three-day wait).

An issue which is probably going to have to be resolved by litigation, is whether the period during which an applicant receives Labor Code §4850 pay is counted against the overall two-year limitation on temporary disability set forth in Labor Code §4656. The Association's argument is, obviously, that it does not, grounded primarily in that Attorney General's opinion that the benefit, while similar, is not the same.

It was pointed out that an applicant's concurrent employment can have a devastating effect on his right to Labor Code §4850 pay, however, since an employer is entitled to credit for wages earned during a period of entitlement to Labor Code §4850 pay. Hupp v. WCAB, 60 CCC 928 (1995). This is especially problematic in a situation where applicant earns more from his concurrent employment than he does as a public safety officer.

The end result of all of this is the potential disability retirement. The panel's observation was that, over time, the Courts (and perhaps the employer) has lost sight of the true purpose of a disability retirement, as set forth in Government Code §20001: the purpose is to promote economy and efficiency in the public service by providing a means whereby incapacitated employees, without hardship or prejudice, may be replaced by more capable employees. Thus, the panel complained about the latest reiteration of what is required to establish the right to a disability pension by the

Supreme Court in Nolan v. City of Anaheim, 33 C. 4th 335 (2004), where it was held where a police office would not only have to show that he was incapacitated from continuing to perform his usual duties in his former department, but also that he was incapacitated from performing the usual duties of a patrol officer for other California law enforcement agencies covered by PERS. Quite a contrast from the observation of the court in Pathe v. City of Bakersfield, 255 CA 2d 409 (1965) to the effect that disability retirement provides a means for public employers to remove an incapacitated worker for the good of the service.

To a certain extent, the decision in Nolan could work just as great a hardship on an employer seeking to replace its employee, since disability retirements can be voluntary as well as non-voluntary (the latter case being where the employer initiates retirement proceedings). Government Code §21153 provides that a governmental employer may not separate an applicant otherwise eligible for a disability retirement from his employment because of disability, but rather shall initiate proceedings for a disability retirement (subject to several exceptions). Similar is Government Code §19253.5(I), which provides that if the employer concludes that the employee is unable to perform either his usual and customary work, or any other position within the agency, the employer shall file an application for disability retirement on the employee's behalf.

It would appear, however, that the retirement board's determination with respect to entitlement is governed by the same rules, no matter who files the application. That is problematic for the employer, since, if the retirement application is denied, the employer must reinstate the employee to his position, with back pay and benefits (less specified credits) (Government Code §19253.5(I)(3), and the practical effect here could be that the employer would be forced to keep applicant on the payroll even if he cannot perform any work.

The effect of termination on a right to disability retirement depends upon when the

termination takes place. If the termination occurs after an individual has become eligible for retirement, a termination, even for misconduct, cannot destroy that right. Praub v. Board of Retirement, 34 C. 3d 793 (1983). In Praub, applicant claimed to psychiatric injury resulting from his employer's investigation of an ultimately unproved charge, and the court held that this was, in fact, a service-connected injury (a somewhat fine line; had the charges been proven and applicant terminated as a result, the result might have been different). This seems to have been the case in Haywood v. American River Fire Protection District, 67 CA 4th 1292 (1998), where applicant was terminated for cause, and then alleged a stress based injury based upon that termination. Since applicant had no claim for psychiatric disability prior to his termination, he was not eligible for a pension.

Applicant attorneys were cautioned, however, not to let their clients resign, since that severs the employment relationship (noting that the Haywood court indicated that a retirement does not sever the employment relationship). A resignation could terminate the employee's right to a retirement.

VIII.

OTHER ISSUES

We previously mentioned Green v. WCAB, 70 CCC 294 (2005) in connection with the retroactivity issue, but its concurrent issue related to the application of the penalty statute, Labor Code §5814. There was some strange language in this section, notably the provision that old Labor Code §5814 would be inoperative for six months. The court held that that was simply to avoid the newly-enacted statute of limitations for filing penalty claims, rather than providing a period during which such claims could be filed and adjudicated under the old rules. Thus, the new penalty statute applies to all claims which were not adjudicated, prior to the effective date of the statute.

With respect to issues of temporary disability, a non-published opinion, Borges v. WCAB, actually took a look at a practice which is somewhat prevalent in a defense community, that being the practice of telephoning the examining doctor on the date of the evaluation, obtaining a telephone status, and immediately making a benefit determination (such as cutting off temporary disability) on the basis of that report. The Borges court said this is impermissible, and that in order for a benefit determination (such as a termination of temporary disability) to be valid, it must be based upon substantial medical evidence, i.e., an actual medical report; until the report is physically in the hands of the claims examiner, medical evidence does not exist. We suggest this be kept in mind.

CIGA had several significant wins in California Insurance Guarantee Association v. WCAB (American Motors Insurance Company), 70 CCC 556 (2005) and California Insurance Guarantee Association v. WCAB (Argonaut Insurance Company), 70 CCC ____ (2005), the effect of which was to vacate Gomez/Nokes, an En Banc decision which suggested that there might be a right of contribution/indemnity against CIGA for medical expense and/or temporary disability in proportion to the need for that benefit created by specific injuries which were solely within CIGA's coverage. The gist of these cases is that there is never a contribution right against CIGA where a solvent insurer (or self-insured employer for that matter) has joint and several liability for a particular benefit. If other insurance is available to pay the claim (Insurance Code §1063.1[c][9]), then the solvent carrier pays (the underlying holding in Gomez/Nokes, which was not disturbed was that, in these joint cases, the solvent insurer should administer the claim), and there is no right of contribution, indemnity, or subrogation under Insurance Code §1063.1(c)(5) and (c)(9). The court's underlying rationale was that CIGA was not created by the legislature to diminish responsibility of other carriers to provide coverage.

The Uninsured Employer's Fund was saved from itself in Rea v. WCAB, 70 CCC 312

(2005), a matter more of academic interest to the rest of us than anything else. UEF had been taken to task by the Board for not only not cooperating, but essentially being an impediment, to an applicant's attempt to identify an uninsured employer. The Board stated that, under these circumstances, UEF could be joined and forced to participate in the identification process. The Court of Appeal indicated this was not authorized by statute, but suggested an alternative method by which the applicant listed the employer as a "doe", and then serves the Notice of Lawsuit on the fictitiously named employer (presumably, he knows where the employer is located, although we wonder if publication would be possible). Once that is done, UEF may be joined, and then can be forced to participate in the identification process.

Finally, and very significant for the defense, is the California Supreme Court's decision in Honeywell v. WCAB, 70 CCC 97 (2005), confirming the opinion of the Court of Appeal before it that Labor Code §5402 means exactly what it says: the 90-day period in which to deny an industrial injury commences only from the date a claim form is properly served upon the employer, absent a showing of estoppel. The court went on to say that four elements must be present in order to establish an estoppel: the party to be estopped must be apprised of the facts; he must intend that his conduct shall be acted upon, or the other party must reasonably believe it was so intended; the other party must be ignorant of the true stated facts; and he must rely on the conduct of the other party to his injury.

Here is a common scenario that most of us have seen from time-to-time: an employee reports to an appropriate manager that he sustained an industrial injury, but the report is late (for whatever reason, the most common probably being a claim by the employee that he thought he would get better, allowing a week or two to go by in the interim). The employee requests a claim form, and requests that he be sent to a doctor. The employer refuses both, telling the employee that it is too

late to report the injury, and that if he needs medical care, the only way for him to obtain it is on his own.

Is this an estoppel? We think virtually every judge will think it is.

IX.

CONCLUSION

The tenor of this convention was to the effect that there will be some dramatic shifts in the manner in which applicant attorneys view their cases. Rather than the primary interest being a prolongation of periods of disability for as long a time as possible, the suggestion is that we will see a somewhat rapid 180 degree shift toward putting pressure on employers to take their employees back, either in modified or regular capacities, and there will be increasing pressure upon employers to accommodate disabled employees, or to specifically and in detail show why they cannot. Where it becomes clear during a period of temporary disability that a person will not be able to return to work for his employer, we will probably be seeing applicants attempting to establish rights to their vouchers so they can undergo training while they are receiving temporary disability, so as to not have to undergo a period of training without a temporary disability income.

Employers are going to have to make genuine efforts to accommodate injured employees in this new system. Quite frankly, employers also need to be educated with respect to the method of responding to reports of industrial injury: they should not, under any circumstances, tell an employee that it is too late, or they have waived their rights, etc., but when confronted with a report of an industrial injury, should immediately give the applicant a claim form, forward the information to the appropriate carrier or risk administrator, and send the employee off to the industrial clinic. Not only will this avoid the estoppel problems described in Honeywell, but it will also assist a defendant in maintaining medical control. Applicant attorneys are correct: if an employer plays fast and loose

with the report of industrial injury and does not appropriately provide medical care, the right of medical control within a network may well be lost.

From a carrier standpoint, we all know that utilization review probably needs to be more efficient. Utilization review reports need to be treated in the same manner as any other medical report; they need to be immediately filed and served. The next big case on exclusion of utilization review reports is probably going to come in a situation where an applicant's attorney was not served with the utilization review report and he is going to argue that, under those circumstances, a defendant cannot rely upon it in making a benefit decision with respect to his client.

Finally, in terms of time lines, we can hear the drum beats. The Sandhagen case is out there for all applicant attorneys to use, and, eventually, as they get used to this new system, they will pretty much uniformly be looking at whether or not the utilization review time lines have been followed.

Unfortunately, none of our lives have really been simplified by SB899. Instead, the world of workers' compensation appears to have become increasingly more technical. In the end, benefit expenditures are probably quite a bit less (despite the bravado of a number of the Southern California attorneys, we think the days of fleecing by medical lien claimants is coming to an end), but the method of reaching those points has actually become a little bit more complex.

It would be nice to see the ACOEM issues go away through the adoption of a schedule by the Administrative Director, but who knows when that will happen. We will almost certainly begin seeing increasing use of vocational evaluators to be used in conjunction with evaluating doctors. What affect that will have on the new disability schedule, or in the method of evaluating disability, is unclear.

We will see what happens over the next six months until the next convention.

If you have any questions, comments, criticisms, or condemnations, please feel free to give any of us here a call and we will do our absolute best to be responsive. If you would like any of us to hold informational groups or seminars with respect to the topics covered by this report, or any topics at all, please let us know, and we will be happy to schedule something.

Until the next report,

Very truly yours,

BENTHALE, NICHOLAS & McKIBBIN

By: MICHAEL K. McKIBBIN
Attorney at Law

MKM/bev
Attachment