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, 2006

MONTEREY, CALIFORNIA

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

2006 SUMMER CONVENTION OF THE

CALIFORNIA APPLICANT ATTORNEYS' ASSOCIATION

MONTEREY, CALIFORNIA

JUNE 22 - 25, 2006

LADIES AND GENTLEMEN:

As has become our practice, we attended the 2006 Summer convention of the California Applicant Attorneys' Association, which took place in Monterey, California. Compared to the conventions which have taken place in the immediate aftermath of various recent significant workers compensation legislation, this one was relatively calm. They have run the gauntlet from panic (a shrill warning during the Winter convention just prior to the passage of SB 899 that, if the measure passed, only a handful of workers compensation attorneys would survive in this state, a warning which, so far, judging by the size of this convention, has pretty much proven to be untrue) to outrage, defiance, and now, to a certain extent, acceptance (at least to the extent that applicant attorneys are now seriously attempting to grapple with methods by which they can make the new legislation work for their clients). Thus, the primary focus appears to be away from all out or large scale attacks on the legislation itself, but rather, again, to the primary objective of conventions in years past: maximizing the dollars.

That is not say that the Association has completely settled in with SB899 and all of its (at least to them) adverse fall out. The Association is still deeply dissatisfied with the new permanent disability schedule, although the complaint here is not a shotgun approach in the direction of the

AMA Guides themselves, but rather at the administrative regulation adopting the permanent disability schedule as an implementation of the AMA Guides, with the primary target being (again) the future earning capacity variant. One well-known applicant's attorney has gone so far as to attempt to put the whole schedule on trial, calling witnesses instrumental in the formulation and adoption of the schedule to the witness stand, and, (according to him), eliciting testimony from them that the future earning capacity variant was based on nothing either empirical or objective, but rather was just pulled out of thin air (he indicates the case settled for a large amount of money after the first day of trial). Apparently, the Official Transcript of Informational Hearing on Workers' Compensation: Proposed Disability Schedule, Senate Commission on Labor and Industrial Relations (pages 16-20), shows the former Administrative Director, Andrea Hoch, testified on December 7, 2004, that she did not rely on data from additional empirical studies [mandated by Labor Code section 4660 (b)] because she could not locate any such data. We anticipate that applicant's attorneys will continue making this attack on the new permanent disability schedule until some sort of appellate judicial decision is rendered on this subject.

In the meantime, the full Workers' Compensation Appeals Board, in an en banc decision which issued on June 21, 2006, erased the underlying trial court aberration which decided that the new permanent disability schedule applied only to injuries occurring after January 1, 2005 (Elizabeth Aldi v. Carr, McClellan, Ingersoll Thompson & Horn, ____ C.C.C. _____ (SFO 0485703, June 21, 2006). The full Board found that the underlying trial court decision failed to comply with the requirement of statutory interpretation that meaning be given to every word, and that no portion of the statutory language should be regarded as surplusage. The Board held that the revised permanent disability rating schedule applies to all pending cases, including cases where the

injury occurred prior to January 1, 2005, when there has been no comprehensive medical/legal report or no report by a treating physician indicating the existence of permanent disability, or when the employer is not required to provide the notices required by Section 4061. What is interesting here is that this language appears to be consistent with a prior memorandum issued by the Administrative Director to the effect that the date of the permanent and stationary evaluation is not determinative with respect to which schedule is used but rather it is the date on which the report itself issues (i.e., the evaluation might have taken place prior to January 1, 2005, but if the report with respect to that evaluation did not issue until after January 1, 2005, the new schedule applies). As yet, we are not aware of an appellate decision directly on this issue, but we are sure it is coming soon.

Aside from attacking the schedule itself, the other tactic is essentially avoidance of the schedule with the use of the vocational expert for the purpose of performing a functional capacity assessment (basically, customized opinion with respect to diminished future earning capacity). The argument here (which has been developed over the last year) is that the revised permanent disability schedule is only "prima facie evidence of the percentage of permanent disability" [Labor Code Section 4660 (c)] again, which means that it only establishes a rebuttable presumption (presumption effecting the burden of proof, Evidence Code Section 602). The idea is that expert testimony to rebut the permanent disability schedule has long been allowed in worker's compensation proceedings (essentially beginning with LeBoeuf v. WCAB, 408 C.C.C. 587) and is based upon the assertion that expert testimony is more accurate than the schedule itself for the purpose of proving the percentage of actual permanent disability.

Quite frankly, by the time of this convention, we would have expected the Association to be trotting out more trial court decisions involving this issue (it was our impression that there were

several San Jose cases under submission at the time of the last convention; perhaps they did not go the way applicant attorneys had hoped). One trial court decision has come out of the Grover Beach Workers' Compensation Appeals Board, Veronica Navarro v. Arbor View Retirement Community, GRO 32504, in which the AMA rating in connection with the impairment found by the agreed medical examiner would have been zero, but the judge felt that testimony of a vocational expert more accurately described this applicant's disability. The expert indicated she took a multi-step approach to analyzing applicant's diminished earning capacity, which included a review of the medical records, a personal interview with the applicant, research of applicant's wages, and a post-injury earning capacity analysis. Her conclusion was that applicant suffered a fifteen percent earning capacity loss, and the judge issued a fifteen percent award (interestingly, there was no adjustment for age or occupation). There will be no appellate decision arising out of this decision, since the defendant declined to appeal, and simply accepted the award.

A lot of things have been decided with respect to the new law, but multiple issues remain before the dust settles. Since the Association seems to be redirecting at least some of its focus to more practical aspects of Workers Compensation, that is, maximizing the dollars, that's where we'll start.

I.

MAXIMIZING BENEFITS AND THE USE OF SECONDARY DISABILITIES

We start with idea that this practice is medicine based. That is, all decisions relating to benefit entitlement arise out of opinions relating to an applicant's medical condition. Because this occurs in the context of a judicial proceeding the medical opinions must be substantive enough to qualify as admissible and substantial evidence. Thus, a doctor's opinion does not constitute

substantial evidence if it does not rest upon relevant facts or if it assumes incorrect legal theory. Zemke v. WCAB, 33 C.C.C. 358 (1968); Hegglin v. WCAB, 36 C.C.C. 93 (1971). The courts have expressed concern with the level of understanding of physicians with respect to what is required to sustain a legal decision, with a Court of Appeals in one case stating that it did not comprehend how the parties could expect any physician to properly report on workers' compensation matters unless that physician was advised of the controlling legal principles. Gay v. WCAB, 44 C.C.C.817 (1979). We supposed that this is a legal justification for infomercial letters to the doctors, explaining, in detail, the nature of the issues, and the information his opinion must contain in order to adequately address those issues.

To a large extent, this is why the Northern California Workers' Compensation community cannot understand the Southern California community's insistence upon using joint agreed medical examination letters (which is said to be completely devoid of any information whatsoever, other than the generic description of the issues to be addressed). The other extreme, however, are the rather colorful and argumentative letters authored by some of our brethren (Attorney Arthur Johnson's letters are a classic example) which not so subtly suggest to the physician how the report needs to be written (one physician panelist commented that some of the letters he receives are longer than his reports; and while that physician advises that he does appreciate a brief overview of the specific issues to be addressed, and the controlling legal principles, he advises he considers himself intelligent enough to make up his own mind on the medicine once he has this information).

The primary areas of dispute generally are going to be with respect to one of the following areas:

(1) Temporary disability, defined, essentially, as physical or mental impairment or incapacity which is reasonably expected to be improved or cured with medical treatment (it need not be total, and an applicant is capable of working while he is temporally disabled). There is case law to the effect that temporary disability continues until the doctor's report stating that the injured worked is permanent and stationary has been served on the worker (or his attorney). Alliance Insurance Company v. WCAB, 47 C.C.C.416 (1982); Chevron USA v. WCAB, 51 C.C.C. 2 (1986).

(2) Permanent and Stationary Status. Generally defined in Administrative Rule 9785 as being the point where the employee has reached maximum medical improvement, meaning that his or her condition is stabilized, and unlikely to change substantially with or without medical care. Several cases state that until all reasonable healing modalities have been attempted and all reasonable diagnostic testing completed, the injured worker is not permanent and stationary. Wyland Entertainment v. WCAB, 40C.C.C.617 (1975); City of Glendale v. WCAB, 47 C.C.C. 168(1982).

(3) Permanent Disability.

(4) Apportionment and this, of course, is one of the hot button issues, since the apportionment statutes have been substantially changed.

(5) Causation and Injury AOE/COE (whether it is more likely than not that the work exposure contributed to, aggravated or accelerated the development of injury).

(6) Medical Treatment.

This is covered because there is a realization that the medical evidence is going to become increasingly important, especially in an environment where even the Association, to an extent, concedes that the AMA Guides, and the permanent disability schedule based upon them, may be here to stay. Thus, the present investigation to a large extent relates to how to maximize the case even if

they are constrained by a AMA based permanently disability schedule. It certainly appears that the type of industrial injury impacted the most adversely by the implementation of a AMA type schedule is the Orthopedic injury (which, not coincidently, is the most common type of injury found in a workers' compensation case).

Thus, what is going to be extensively explored in connection with orthopedic injuries is the so-called compensable consequence claim (also referenced during this conference as "secondary disability"). In essence, a compensable consequence injury is one which arises because of the result or effect of a prior injury. Thus, for example, a knee injury results in an altered gait, and the use of a crutch, an applicant develops back pain and wrist pain as a result. Such claims which would have the potential for expansion of the body parts involved in a primary injury are going to be watched very closely in the future. Compensable claims are not new injuries, and do not require the filing of a new additional application or claim form. In fact, the association believes an amendment to the original application/claim form is not required, but we are not sure that this is actually true, and the panelists acknowledged that claims examiners generally insist upon amendments (as do most defense counsel).

All of us are very familiar with the expansion of orthopedic claims to other body parts (such as the example referenced above). Applicant's attorneys, however, are going to be looking beyond additional orthopedic injuries, and to other fields of medicine based upon the concept that non-orthopedic conditions, particularly internal medicine conditions, rate significantly higher under the AMA guides than do orthopedic conditions (in addition to the internal medicine add ons, we more than likely will be seeing more psychiatric add ons as well, since the AMA Guides really did not significantly adversely effect the manner in which these disabilities were rated either).

It is true that applicant's attorneys are a little less able to control the direction of medical reporting (although, we think, that in a denied case an applicant's attorney may have a significant advantage in connection with the development of medical reporting, since an applicant is capable of self-procuring medical treatment with pretty much anyone he wants, and the reports of those physicians, as treating physician reports, are admissible). However, the convention panelists point out that the AMA Guides require a physician to examine the "whole person", rather then simply the body part alleged to be injured. The panelists, in fact, express some impatience with QME's who restrict their comments only to the particular field of medicine within their speciality (i.e. Orthopedics), and defer comment to physicians in other specialities with respect to other conditions. As they quite correctly point out, all these physicians have gone to medical school, and received at least basic training in all fields of medicine, so they feel that there is really no legitimate excuse for a QME to fail to at least attempt to comment upon conditions outside of their specialities, and render at least preliminary opinions with respect to them. We think we will see more of an attempt by applicant's attorneys to have QME's doing this (which means, even from the applicant's side, we may be seeing more depositions).

The types of secondary disabilities we may be seeing are as follows: sleep disorders (either in connection with the taking of medication, or as a result of interference due to pain); sexual dysfunction (again medication use, but the potential for this also arises in back cases and, interestingly enough, a total loss of sexual function results in a twenty percent whole person impairment); hypertension/heart problems (stress arising from injury); peripheral vascular type diseases (such as phlebitis, allegedly caused by lack of activity and certain types of trauma); gastrointestinal (primary related to medication used, although occasionally stress); liver disorders

(medication used); blood disorders (allegedly from the accumulatively effect of chronic pain, stress, medications); diabetes (from excessive wight gain associated with decreased physical activity, and/or due to medication effects, although this would more than likely be an aggravation; chronic extremity pain syndrome (which is recognized as an impairment in Chapter 13 of the guides); metabolic syndromes (this is going to be controversial, since this actually involves a combination of symptoms); and, of course, psychiatric disorders.

The possibilities for these types of claims is enhanced by the nature of the worker's compensation system. Not only is the system itself sympathetically disposed to exploring methods of enhancing an injured worker's compensation (especially in connection with a new schedule which is perceived as being stingy), but the standards of proof with respect to causation are, as a practical matter, quite a bit more flexible than they are in civil court. Thus, there is the liberal construction mandate of Labor Code Section 3202, and the standard of proof from a medical stand point is one of reasonable probability, which requires a finding of industrial causation even though the exact causal mechanism is unclear or is unknown. McAllister v. WCAB, 33 C.C.C. 660 (1968).

II.

APPORTIONMENT

This, of course, remains a continuing volatile issue. The most significant development, of course, was a very recent decision of the court of appeals in Nabors v. WCAB, 71 C.C.C. (June 8, 2006), which followed the reasoning in E & J Gallo Winery v. WCAB, (Dykes), 70 C.C.C. 144 (2005). Dykes rejected apportionment by the subtraction method in the case of an employee of a self insured entity who had sustained multiple injuries with that employer, one of which was the subject of a prior award, but instead determined that the defendant was only entitled to a monetary credit

against its current liability based upon the value of the prior award. The rational was based upon the liberal construction mandate of Labor Code Section 3202, as well as the principle that applicants' should be fully compensated for the disability caused by their industrial injuries. Dykes, was limited to its facts (multiple injuries and a prior award with a single, self insured employer); and Nabors was different only in that there were different insurance companies involved (although both the injury which resulted in the prior award, and the injury at issue, occurred with the same employer). The court felt that the distinction made by Dykes as between its factual situation and that involved in Nabors was a distinction with out a difference.

Nabors and Dykes involved two of four types of apportionment cases, and we think that the Nabors/Dykes rational will be applied at least to the third type of case: multiple industrial injuries, at least one of which is resulted in a prior award, but occurring with different employers. The rational appears to apply equally: injured employees should be fully compensated for their industrial injuries. It is noted that all of these cases involved interpretation and application of Labor Code Section 4664.

It is the fourth category of case, where medical evidence reveals that a portion of applicant's injury is non-compensable (the Labor Code Section 4663 case) where there may be an opportunity for arguing that there is a true distinction, since the principle of an applicant being fully compensated for his industrial disability does not really apply here. In fact, the argument is that an application of the Nabors/Dykes formula would discourage employers form hiring previously disabled persons. For example, a simple, soft tissue back injury could result in catastrophic disability payments for an employer of an individual who previously suffered the effects of a debilitating disease , such as polio. Panelists were arguing that such a case would be unfair to an applicant who had not been compensated for his underlying disability, but the question is, compensation by whom and for what?

The panelists also pointed to the difficulty of applying the Labor Code Section 4664 apportionment under the old schedule to the disability determined under the new schedule, but that problem does not present itself in the Labor Code Section 4663 situation, where only the disability being considered at the moment (whether under the old or new schedule) is the subject of an apportionment (and probably in connection with impairments, would be measured by way of percentage).

In any event, all of the other apportionment scenarios are presently in front of the Court of Appeals. In the next year or so, we should have answers.

It is certainly clear that the rule with respect to apportionment has significantly changed (new Labor Code Sections 4663 and 4664, and the interpretation of Labor Code Section 4663 set forth in Escobedo v. Marshall's, 70 C.C.C. 604 (2005). Prior to SB 899, the defendant needed to show that, prior to the compensable injury, applicant already had a disability which affected his ability to compete in the open labor market, or the impairment of earning capacity, or the use of a member. Apportionment to pathology was not legal apportionment, and a physician was required to demonstrate adequate familiarity with the preexisting disability. Gay v. WCAB, 44 C.C.C. 817 (1979).

Labor Code Section 4663, as interpreted by Escobedo, certainly allows apportionment to additional factors, including pathology, although it is probably true that merely showing the existence of a pathological condition is not enough. Although we are skeptical about the applicant attorneys' argument that pathology itself is not apportionable unless it produces a preexisting disability (we think this is simply an attempt to revert back to the old apportionment rules), we think that if it cannot be shown that it is "reasonably probable" (to used applicant's burden) that some sort of disability would eventually result in the average patient, the defense is going to have trouble.

Thus, Sherman v. Los Angeles Unified School District, 2005 Cal. Wrk. Comp. P.D. Lexis 37 (October 28, 2005), may not be much of a surprise. In this case, applicant had an industrial injury which lit up a preexisting, asymptomatic rheumatoid arthritis which proceeded to result in almost total disability. The agreed medical examiner conceded that the industrial injury did not cause the rheumatoid arthritis, but insisted that the rheumatoid arthritis may have remained completely asymptomatic and non disabling had it not been for the industrial injury. In other words, this was a true "lighting up" case (which Escobedo indicated that it was not addressing). Given these circumstances, the Board found that there was no basis for nonindustrial apportionment.

To a large extent, the result in Aguilar v. Breibenbach Buckley, Hutching & Hamblet, Case Number MON 0246279 (February 21, 2006) is understandable as well, where the Board refused to apportion to obesity in and of itself, stating that it cannot be assumed that simply because the person is obese, he or she is disabled.

In connection with what a physician is required to do in terms of evaluating a prior medical condition for apportionment purposes, Larsen v. Hitachi Globel, Case Number SJO 0249225 (March 13, 2006), involving a summary denial of reconsideration, is probably instructive with respect to what should not be done. In Larsen, had the agreed medical examiner actually been analytical about the effects of a prior back surgery, and what could be expected as residuals in connection with such surgery, the defendant would have probably gotten apportionment. As it was, the agreed medical examiner apportioned fifty percent to the prior injury resulting in the back surgery, and then stated he had simply pulled the figure "out of thin air". That obviously is not going to support an apportionment.

Vargas v. Atascadero State Hospital, 71 C.C.C. 500 (2006) was an important decision with respect to the effect of the new apportionment rules on a petition to reopen. Most of us pretty much figured that an otherwise final award which had issued prior to the effective date of SB 899 was not subject to modification even if a applicant filed a petition to re-open. However, Vargas involved an attempt to apply apportionment to underlying non-industrial symptomatic pathology which contributed to the increase of applicants' disability. In an en banc decision, the Board found that proceedings with respect to new permanent disability (such a petition to re-open) must be determined under the new apportionment statute based upon the standards set forth in Escobedo.

In connection with the interpretation of Labor Code Section 4664, with the effect of prior awards, Pasquoppo v. Hayward Lumber, 71 C.C.C. 223 (2006) involved the issue with respect to whether an approved Compromise and Release was an "award" for apportionment purposes under Labor Code Section 4664. In an en banc decision, the Board held that it was not a "prior award of permanent disability" within the meaning of Labor Code Section 4664, and that apportionment with respect to a previous case settled by way of Compromise and Release had to be determined pursuant to Labor Code Section 4663 (also suggesting that medical rehabilitation might be a legitimate issue in such a case). There is some thought that inserting a percentage of disability into the Compromise and Release itself might convert it into an award, but, as a practical matter, Compromises and Releases generally involve a compromise on the level of disability.

Finally, a completely terrible (and in our humble opinion, completely wrong) case is the panel decision in Steinkamp v. City of Concord (citation not available, but date of decision is March 30, 2006), in which applicant had a badly degenerative knee prior to his industrial injury to that knee, and then had a knee replacement following the industrial injury. Medical evidence was to the effect

that applicant had significant medical attention with respect to the knee prior to the industrial injury, including a recommendation for a knee replacement. In the end, the agreed medical examiner felt applicant was limited to semi-sedentary work, and that this work was restriction was totally due to applicant's right knee replacement.

The Board felt there was no basis for non industrial apportionment, noting that, even though a variety of factors, industrial and non industrial, were responsible for applicant's knee replacement, medical treatment is non apportionable, and since the applicant's work limitations were totally due to the knee replacement and symptoms related to the prosthesis (i.e. totally related to the medical treatment), there was no basis for non industrial apportionment.

This reflects a panel which sat in the hot sun for far too long. Of course medical treatment is non apportionable (although, even as an absolute, this is not true, since medical treatment can be apportioned as between defendants in a contribution proceeding), but permanent disability certainly is. Defendants frequently provide medical treatment for conditions which may be caused, in part, by non industrial factors, but that does not mean those non industrial factors are not to be to taken into consideration in connection with the benefit which is, in fact, apportionable, permanent disability.

III.

MEDICAL AND OTHER DISCOVERY

Despite the asserted simplification of medical discovery by the replacement of the old QME system by a panel system, we suspect that the system is subject to some "gamesmanship", the result of which could be multiple medical evaluations. At least with respect to injuries occurring prior to January 1, 2005, the courts have continued to confirm that the medical discovery method is essentially the "free choice" QMEs which were permitted under former Labor Codes Section 4060,

4061, and/or 4062. Nunez v. WCAB, 71 C.C.C. 161 (2006); Cortez v. WCAB, 71 C.C.C. 155 (2006).

There is still a two tract approach to obtaining medical evaluations for injuries occurring after January 1, 2005, one for unrepresented applicants, and one for represented applicants. To an extent, the tract for unrepresented applicants remains essentially the same as it was prior to January 1, 2005, with the exception that, if the applicant fails to choose a doctor ten days after issuance of the panel, the defendant can chose the doctor and set the appointment. The practical difference, however, is that the Association is now urging its members to carefully explore the time lines and other procedural requirements in connections with the evaluations of unrepresented applicants (if the applicant shows up in an attorney's office after the QME evaluation has been conducted). If the technical requirements were not followed exactly, this would give a basis for requesting a new panel (especially in a case where the opinion of a panel QME was unfavorable to the applicant). Obviously, they do not expect this in all cases. They note that the new procedure with respect to medical determination of injury AOE/COE is probably more favorable to the applicant than the defendant, since the defendant can no longer pick its own doctor (we're not so sure about this, as noted below). Basically, to obtain admissible medical reporting (and this is probably true) in connection with an injury AOE/COE issue, the defendant must comply with Labor Code Section 4060, and either Labor Code Section 4062.1 or 4062.2 (depending upon whether applicant is represented or unrepresented). In the case of an unrepresented applicant, the parties are restricted to a panel QME; where applicant is represented, the parties have the option of using an agreed medical examiner.

The question, however, is whether admissible reporting is really required for the purpose of making a threshold determination as to whether or not injury AOE/COE is to be accepted. It is noted

that Labor Code Section 4050 allows the defendant to obtain a medical evaluation at any time deemed reasonably appropriate and Labor Code Section 4064 suggests that the parties are permitted to obtain qualified medical evaluations at their own expense. It is clear that a Labor Code Section 4050 evaluation (assuming that is all it is), is not admissible, and most of the community is skeptical with respect to whether the qualified medical evaluation referenced in Labor Code Section 4064 would be admissible either,. However, we are not really aware of anything which precludes the use of such an evaluation in making a threshold evaluation of whether or not to accept responsibility for an industrial injury (something to consider, considering that compliance with the formal requirements of Labor Code Section 4060 could well take beyond 90 days).

In connection with events occurring prior to the evaluation, applicant attorneys will be primarily looking at time lines: was the panel list issued within 15 working days after receipt of the request (Labor Code Section 139.2(h)(1) (as applied to unrepresented cases); did the evaluation take place within 60 days of making the appointment [Rules 33(c) and 31.5 allows for replacement QMEs if not]. Non-time line issues relate to whether the proper procedures were followed in connection with submission of the request form (were the appropriate forms furnished the applicant), whether there was a change in applicant's residence; or whether there was a relationship between the panel QME and applicant's treating doctor (neither the same doctor, or in the same group, Rule 31.5(a)(4)(b)(1) whether the appointment location is at the same address is listed on the list, whether applicant had to wait for more than an hour or whether transportation expenses were paid, whether copies of all documents sent to QME were sent to applicant on a timely basis, etc. (see generally, Labor Code Section 139.2, and rules 31.5, 33, and 41). A number of these objections apply equally to represented and non-represented applicants.

After completion of the QME evaluation, applicants will be looking with respect to whether there were any ex parte communications (there is some case law to the effect that even an inquiry to the office staff of a QME and/or AME with respect to the whereabouts of a report, assuming the other party was not notified, could be considered an ex parte contact) (Labor Code Section 4062.3(f); Rules 335(f) and 401(b); consideration of non-medical records without the consent of the other party; a new claim of injury occurring after the evaluation; a late panel QME report (the QME has 30 days to prepare and submit the evaluation report, Labor Code Section 139.2(j) and 4062.5; Rule 38(a) and (c); improper service (the argument being that improper service constitutes a late report under Rule 36(a) and/or 38(c)); a late supplemental QME report (required within 60 days of the request for such a report pursuant to Rule 38(f); symptoms outside the panel QME's scope of practice (somewhat inconsistent with observations by other panels that QME's should attempt to conduct overall evaluations).

The idea behind all of this is to give applicants (although we suspect this cuts both ways) the opportunity to argue for entitlement to as many panels as they can possibly get, for the purpose of attempting to avoid unfavorable reporting. Once it has been determined that the applicant is entitled to a new panel QME, the reporting of the prior QME is deemed inadmissable (although we wonder if this is an absolute rule especially if the prior QME has submitted multiple reports in the past).

We say this because there are issues relating to the time lines for a re-evaluation (there do not appear to be any specific time lines for a reevaluation, although the issue is whether the time lines for an initial evaluation would apply). There is also an issue with respect to whether the deposition of a panel QME actually qualifies as a supplemental report, which would require the QME to schedule the deposition within 60 days of request.

There is also the possibility of convincing the appeals Board to appoint an evaluating physicians pursuant to Labor Code Section 5703.5(a), the criteria being that such an evaluation is warranted by the records (which obviously leaves a lot discretion to the judge).

Quite frankly, while there is a pretty comprehensive regulatory scheme in place with respect to the use of panels for unrepresented applicants, the rules and regulations for the assignment of QME panels in represented cases are scant. In fact, the Department of Industrial Relations has not even promulgated a form for a panel request in a represented case, instead requiring the parties to use Form 106, which is the form which was developed in connection with unrepresented cases. Thus, a number of time limits discussed above are only specifically applicable to unrepresented cases; they do not necessarily apply to a represented case. On the other hand, there is probably no authority which permits a defendant to obtain it's own QME if the Administrative Director fails to reply to its request for a panel QME within 15 working days (our experiences show delays of over a month). Although analogies can probably be drawn, however, the appropriate remedy might be requesting of a status conference before the Board and utilizing the Board's authority to appoint an appropriate evaluator.

At present, in requesting a panel QME in an represented case, the Department of Industrial Relations is requiring a completed IMC Form 106, the medical speciality of the physician being requested, the medical specialty which the opposing party feels appropriate and a copy of the first written proposal naming a proposed AME. In the event of an objection to a panel or QME (basically, pursuant to an effort to obtain a new panel), the QME complaint form must be submitted.

We previously briefly mentioned the concept that a subsequently alleged injury could justify the appointment of a new QME. It was noted that Labor Code Section 4062.3(i) indicates the panel

QME is to address all injuries, on one or more claim forms. The D.I.R. has even taken the position that this could apply to claims filed at appreciable periods in the past. From applicant attorneys' standpoint, however, their view is that if there is an apportionment to pathology, this could justify the filing of a new cumulative trauma claim with respect to that pathology which in turn would warrant appointment of a new panel (since, technically, evaluation of the new injury would not be a re-evaluation of the old injury, although, depending upon the circumstances, we would probably certainly argue that it is).

Labor Code Section 4062.3 and Rule 35 govern what information is to be submitted to the AME/QME, with the primary restriction being upon non-medical information. Basically, a consent of both parties is necessary to submit non-medical information and, if the party doesn't consent then it is off the Board for an appropriate determination.

Finally, it should be noted that minimum face to face time with a physician is required in connection with these evaluations, ranging from a minimum of 20 minutes in an orthopedic case, to an minium of 1 hour in a psychiatric case (Rules 49.2 - 49.9).

Although we do not expect to see this as a universal practice, applicant attorneys take the position that their clients are entitled to audio tape medical evaluations. We know there is some authority for this in connection with the so called independent medical evaluation conducted in a civil case, and cannot really see any reason why the same rationale would not apply in workers' compensation. From what we understand, the practice would probably be restricted to the case where the physician has developed a reputation (at least in the minds of applicant attorneys) of misrepresenting histories or statements by applicants. We suspect that if an applicant's attorney insists upon doing this, we would have the right to insist upon sufficient advance notice (we know

there are a number of doctors who would refuse to conduct an evaluation under these circumstances).

One more comment with respect to medical discovery relates to utilization review. The panelists suggest that, in the event of a utilization review decertification, an objection letter be sent demanding production of all information upon which the doctor based his denial (this information is generally described in the decertification letter itself). Panelists seem to feel that, in almost every case, the utilization review letter will refer to a medical management nurse summary prepared for the doctor's review, but that this summary is never produced. A number of the panels believe that a failure to produce all of these materials (pursuant to Labor Code Section 4610(f)(4)), might put an applicant attorney in a position to go straight to an expedited hearing without compliance with Labor Code Section 4062, based upon a contention that a failure to serve the materials demanded renders the utilization review report inadmissable.

We think applicant's attorneys are going to become much more technical, and are going to be insisting upon strict compliance with legitimate discovery demands. If a statute and/or case law indicates that an applicant is entitled to production of certain material, then that material should be provided within the appropriate time limits. A failure to do so could cause prejudice and irreparable damage to the defense of a claim (or any portion of it, for that matter). We still continue to be amazed by applicants' head long rush to undergo medical treatment (especially surgeries) proposed by questionable doctors, especially in the face of medical opinion (even utilization review) indicating the proposed treatment may not be appropriate, but do that they do, and if applicants find a technical basis for defeating the utilization review, we think they are going to use it.

In connection with document production, we leave the world of medical discovery and take a brief look at the so-called "discovery war". We are not going to say this is what is happening every

time a claims file is subpoenaed, but the discovery war commences with such a subpena, demanding the claims file as defined by Rule 10101.1, which defines the claims file as including, among other things, notes and documents related to the provision, delay, or denial of benefits, including any electronically stored documentation (we refer to those as the claims notes), notes and documentation evidencing the legal, factual, or medical basis for non-payment or delay in payment of benefits, and notes describing telephone conversations relating to the claim which are of significance to the claims handling, including the dates of calls, substance of calls, and identification of parties to the calls.

We realize there is a natural reluctance to release the claims file in response to a subpena but, unfortunately, the rule referenced above describes documentation which is discoverable, and a prompt response within the time limits set by the subpena (assuming the issuance of a valid subpena) is required. In terms of objections, relevance and burden type of objections do not work; objections based on privilege are available.

Privilege generally relates to either the attorney-client privilege, or the work-product privilege. Some of the panelists actually think that reserves are discoverable, but we would fight very hard to prevent that. The panelists' argument is that the reserves are set by claims examiners, and thus not subject to either the attorney-client or work product privileges. We disagree; we think reserves are integral to the settlement process, and especially in the context of a litigated case, are prepared in contemplation of litigation and are thus privileged.

The problem, however, with procrastinating with respect to these subpoenas, is that any right to object might be waived. Evidence Code Section 912 provides that a claim of privilege is waived by consent to disclosure, and that consent can be implied from a failure to claim the privilege. Code of Civil Procedure Section 2031(k), provides in part that if a person fails to timely respond to an

inspection demand, he has waived any objection to the demand, including one based upon privilege, and this was interpreted in Scottsdale Insurance Company v. Superior Court, 59 Cal. App. 4th 263 (1997) as meaning that any and all objections are to be made at the earliest time possible. Thus, even if a legitimate claim of privilege exists with respect to the subpena, it can be waived, and an Order Compelling Production of privileged materials can be made, if the response is not timely.

The appropriate objection to a subpena is a Motion to Quash (assuming that either no compliance, or substantial non-compliance, is contemplated), and the motion must be filed prior to the return date on the subpena (again, assuming there is a valid subpena, although there are reasons for arguing invalidity, such as improper service, an improper return date, etc.).

Normally, most of the claim file is producible, although privileged items should be removed and/or redacted (redaction is most common in connection with the claims notes), and then a privilege log prepared describing what was withheld.

The general rule is that discovery is closed at the time of the MSC. Labor Code Section 5502. Where documents, including video tapes, are to be offered into evidence, copies are required to be served on all adverse parties no later than the Mandatory Settlement Conference, unless a satisfactory showing is made that the documents were not available for service by that time. Rule 10601.

As someone on one of the panels said, however, the law in this case really is with respect to the exceptions.

The most obvious of those are medical reports. Rule 10622 indicates that a medical report shall not be refused admission in to evidence simply because of a late filing, where the examination was diligently sought and the report came in to the possession or control of the party offering it

within the preceding seven days. City of Redondo Beach v. WCAB, 62 C.C.C. 341 illuminated this exception by allowing a report in connection with a medical evaluation which was scheduled after the MSC, but the appointment was disclosed in the MSC statement, and the potential report was listed as an exhibit.

Much of the post-MSC discovery rules developed in the case of sub rosa videos which were obtained after the MSC took place. Obviously, the videos were not available at the time of the MSC, since the film had not yet been shot. The three primary cases on this subject, Guiard v. WCAB, 61 C.C.C. 706; Mills v. Republic Indemnity, 22 CWCR 139; and Caputo v. Fireman's Fund, 26 C.W.C.R. 48, all involve situations where discovery had been left open for limited purposes (not specifically the videos, but for other purposes), and the warning here to applicant attorneys is that if they request that discovery be left open for them to submit something in to evidence, defendants are going to be able to submit something as well.

What is considered to be the rogue case is UPS v. WCAB, 64 C.C.C. 1369, where discovery was actually closed, and the defendant convinced the judge that the videos were unavailable (of course they were, they had not yet been taken prior to the MSC). Quite frankly, we tend to agree that this argument, all by itself, probably should not work (i.e., the video tapes were unavailable, because defendant had not yet taken them). UPS actually seemed to involve a little more; there was evidence to the effect that the defendant actually learned subsequent to the MSC that applicant was engaged in some sort of activity which was inconsistent with his disability claim, and that is what motivated the defendant to obtain the sub rosa. That is more consistent with the rule that not only must the evidence be unavailable, but that defendant could not have reasonably anticipated the availability of that evidence.

The most terrible of the proposed discovery cases (at least from the defense standpoint) is Grupe Company v. WCAB, 70 C.C.C. 1232, where applicant listed a witness on the MSC statement which turned out to be a vocational evaluator, and the testimony of that vocational evaluator was allowed. The court felt there was no obligation to disclose substance of the witness' testimony, and, since the witness had not prepared a report (at least not prior to the MSC), there were no documents to list. Even some of the applicant attorney panelists expressed some discomfort with this type of tactic, thinking it to be not entirely above board, and the judge panelists suggested that most judges, faced with the same situation, would either continue the matter, or otherwise permit additional discovery so as to allow the other party to be prepared.

The other method of post-MSC discovery takes place in connection with developing the record. A trial judge does have an obligation to develop the record (McDuffie v. L.A. County Transit, 67 C.C.C. 138), although that duty cannot be used as a subterfuge to allow non-disclosed, but available, reports in to evidence without a showing of good cause. (Jones v. WCAB, 69 C.C.C. 15). This type of post-MSC discovery, however, requires that the case be tried first, since that is a pre-requisite to the judge determining that the record is inadequate for making a decision. Olivares v. WCAB, 70 C.C.C. 1358.

IV.

SETTLEMENTS

Most of us are familiar with the two primary settlement vehicles, the Compromise & Release, and the Stipulation with Request for Award. There is actually a third hybrid, a Compromise & Release with open future medical. This type of settlement might be well worth considering in a situation where an applicant is adamant about keeping his future medical care, but the case is

otherwise well within the five year period for reopening. Factors to be considered are the potential for reopening, especially in connection with the expansion to additional body parts, i.e., a potential psychiatric claim, a potential chronic pain, claim, or a situation where it is contemplated that there may well be significant exacerbations, or medical care (such as surgery, which would involve prolonged periods of temporary disability). In considering these types of settlements, applicant attorneys acknowledge that it closes off reopening rights; our experience with these types of settlements is that some of them do not realize that it terminates applicant's right to any future temporary disability, (even in the aftermath of a significant surgery) as well.

The panelists are suggesting that, in the case of large settlements, applicant attorneys be more receptive to structured settlements. Studies apparently show that most applicants are out of money within five years of a settlement, where the settlement was paid to them in a lump sum. The conflict, of course, in connection with structured settlements, comes in connection with the use of structured settlement brokers. Everyone wants to use their own. A secondary conflict would almost appear to be the insistence by some carriers that they use either one of their other divisions, or a contracted carrier, with respect to the issuance of an annuity upon which the structured settlement is based.

Actually, the use of these carriers is not so much an issue to the panelists, so much as the use of brokers. They indicate that, in situations where either an in house division, or a contracted carrier is used, the defendant's broker will not explore structured settlement options outside of these particular carriers. On the other hand, it is asserted that an applicant's broker will shop the market for the most attractive rate and, while it is conceded that the defendant cannot generally be convinced to move the business away from its own division or contracted carrier, it almost always will meet

the rate found by the applicant's broker. Ergo, applicant attorneys insist upon using their own brokers.

Gone are the days, we think, where a structured settlement is accepted based upon the payout; applicant attorneys universally these days settle the case based upon the cost of the settlement.

One of the advantages of a structured settlement is that they are tax-free if certain criteria are met (that criteria being that the defense insurance carrier purchases the annuity, rather than applicant or his attorney purchasing it).

What is always going to be an irritating thorn in the side of the community in connection with settlements, is Medi-Care. Medi-Care involvement necessitates a Medi-Care set-aside allocation, which is the vehicle for complying with the Medi-Care secondary payer statutes. A formal Medi-Care set-aide trust is not required, nor is a set-aside broker (although they will generally try to convince you otherwise, and they certainly can be useful in the more complex cases). What is required is that Medi-Care's interests be fairly considered, and that an appropriate allocation be made. For the purpose of determining whether it's interests have been adequately considered, Medi-Care likes to consider medical expenses in the two-year period prior to the settlement, as well as the medical reporting, (in connection with evaluating what an applicant will need in terms of future medical care). It is noted that not all types of medical care are necessarily covered by Medi-Care.

At present, four criteria require the creation of a Medi-Care set-aside allocation:

1) The applicant has applied for or is receiving Social Security;

2) The applicant is 62½ years or older;

3) Any settlement for $250,000.00 or more; or

4) Any settlement for $25,000.00 or more, where applicant is actually receiving Medi-Care.

Denied claims should give the parties some basis for arguing that Medi-Care should accept an adjustment of its allocation. It is perhaps in denied cases involving large settlements that brokers are most useful, since actual negotiations with Medi-Care will be required (these brokers seem to have an access to the Medi-Care contractors that most mere mortals do not).

There is a suggestion that if the parties are dealing with multiple dates of injury, separate Compromises & Releases, each for less than $25,000.00, could be created, but to a certain extent, we think Medi-Care might see this as an overt attempt to shift liability.

Medi-Care would not be such a problem if the agency would promptly act upon allocation proposals (whether private or formal). The problem is that, even under the best of circumstances, Medi-Care approvals of proposed allocations have taken anywhere from three months to nine months and, as of June 1, 2006, Medi-Care is apparently revamping its contracting system, and the new national agency is not going to be ready to begin considering approvals until late in the year. We understand that, until that time, there will be no Medi-Care reviews or approvals of allocations at all. Any settlement dependent on one is just going to have to wait.

The Medi-Care regulations do not specifically require Medi-Care approval of a Medi-Care set-aside allocation, only that Medi-Care's interests be adequately considered, and that there be no attempt to shift liability to Medi-Care. Thus, if the parties feel comfortable enough with an allocation, they can obtain approval of the Compromise & Release without a formal consent from Medi-Care. Despite suggestions to the contrary, we continue to believe that, subsequent to the Compromise & Release, with the exception of pre-Compromise & Release expenditures by Medi-

Care, a defendant would have no liability to Medi-Care for post-Compromise & Release expenditures (at least in the absence of Medi-Care establishing that a defendant was a party to a scheme to, in a way of speaking, to de-fraud Medi-Care). Medi-Care takes the position that a defendant has an affirmative duty of notification with respect to a proposed settlement (this does not appear to be explicitly required by the regulations either, but we advise our clients that Medi-Care should be served with a copy of the settlement document, where one of the criteria is present) and we think this adequately satisfies any post-settlement obligation that defendant might have to Medi-Care. The true risk actually falls on applicant, since Medi-Care suggests it might take a credit in the total amount of the settlement as against any Medi-Care benefits applicant to which might otherwise be entitled.

The panelists cautioned its members to be careful of life care plans, since while they tend to pump up the value of a settlement, they also tend to pump up the value of the Medi-Care allocation.

Obviously, Medi-Care allocations are not required in cases where future medical care is left open, such as a Stipulation with Request for Award, or a Compromise & Release with open future medical.

V.

ACCOMMODATION AND RETURN TO WORK

We are told that with the virtual elimination of a meaningful vocational rehabilitation benefit, injured workers are presented with less options for a return to employment, which in turn increases an employer's potential liability for disability discrimination. Quite frankly, we are not sure how "meaningful" the former rehabilitation benefit actually was. At least in connection with the litigated cases which we saw, it appears applicants utilized vocational rehabilitation primarily as a tool for

the purpose of prolonging disability, as a trap for the purpose of accumulating substantial amounts of retroactive vocational rehabilitation temporary disability, and a justification for the existence of Rehabilitation Units which could not think of enough ways to give away money (years back, the undersigned was involved in a case involving an applicant who, with his own choice of vendor, was re-trained in his choice of occupation, an armed security guard; tested positive for cocaine on the drug test administered on the evening prior to his first day on the new job, which, of course, cost him the job. He requested a new plan on the ground that his drug use precluded his employment as an armed security guard and, during the heated formal rehabilitation conference, the Rehabilitation Consultant said to the undersigned, in all seriousness: "well, your client did not advise him that he would have to take a drug test"). We think the legislature realized that, and that is why the benefit was eliminated effective January 1, 2004. But we digress.

Thus, the Association is urging its members to take a closer look at the Americans with Disabilities Act (ADA), and it's more strict California counterpart, the Federal Employment and Housing Act (FEMA).

The concept of modified/alternative work still exists, although it is now considered in the overall context of whether an applicant is able to return to work for the employer with which he was injured. Generally, within 30 days (there is some suggestion it might be 60 days, but to be safe, use 30) after an applicant has become permanent and stationary, the employer must determine whether it has employment for the applicant, either his usual and customary work, or a modified or alternative position, depending upon the extent of applicant's disability. Basically, the California Fair Employment Housing Act, embodied in Government Code Sections 12926 through 12940, prohibits discrimination in employment based on physical disability, and makes it unlawful for an employer

to fail to make a reasonable accommodation for a known physical disability, or to fail to engage in a timely, good faith, interactive process with the employee to determine effective reasonable accommodations in response to a request for reasonable accommodation.

Physical disability is defined as any physiological disease, disorder, condition, cosmetic disfigurement, or anatomical loss that both affects one or more of the body systems, and limits an individuals ability to participate in major life activities. Government Code Section 12929(k)(1). Physical disability specifically includes such chronic conditions as AIDS, Hepatitis, Epilepsy, Multiple Sclerosis, and Heart Disease, Government Code Section 12926.1(c), although court opinions have included other specific conditions such as back conditions, polio, and hypertension. The definition is probably construed so that employees are protected from discrimination due to either actual or perceived impairment that is disabling, potentially disabling, or perceived as disabling or potentially disabling (including being regarded as having or having had a condition that currently has no disabling effect, but which may become an impairment in the future). Cassita v. Community Foods, 5 Cal. 4th 1050 (1993).

An employer is under an obligation to engage in an interactive, problem-solving accommodation process, including consultation with qualified experts where necessary, with its disabled employee, to identify and implement effective accommodation once an employer becomes aware of the disability, and at least one court has held that initiation of this process is the employer's responsibility. Barnett v. U.S. Air, 228 F. 3d 1105 (9th cir. 2000).

Of course, the employee is required to cooperate. He must be forthright with respect to his restrictions. Jensen v. Wells Fargo Bank, 85 Cal. App. 4th 245 (2000), and the court takes a dim view of lawyers who instruct their clients not to attend interactive process meetings. Furthermore,

an applicant's stipulation during the course of a workers' compensation proceeding that he cannot perform certain types of work, which are the essential functions of the employment offered by the employer, is deemed to be inconsistent with a later claim that the employer failed to reasonably accommodate. Jackson v. County of Los Angeles, 60 Cal. App. 4th 171 (1997).

Defenses to claimed violations of the act include hardship (a demonstration that accommodating an employee's disability would cause undue hardship to an employer's operations, although, the larger the employer, the more difficult it is to sustain this type of defense; inability to perform the essential functions of the job (as opposed to the marginal functions); or where the performing of the position by an individual would endanger their health or the health of others.

If an employee prevails in the action, general, special, and punitive damages as well as attorney fees may be available, although plaintiffs do have a duty to mitigate their damages by seeking employment elsewhere.

As a practical matter, if an applicant is a part-time kitchen assistant making minimum wage, an employer is probably not going to have to be too concerned with a claim that it violated the Fair Employment and Housing Act if an applicant does not return to work. Obviously, any employer has to mindful of the possibility of such a claim (if an applicant has nothing better to do), but we think the real threat of these claims is going to come in cases involving large employers, and rather highly paid employees.

VI.

OTHER ISSUES

A number of recent cases are of interest. In connection with liens, and in particular, surgery center liens, Zenith Insurance Company v. WCAB, 71 C.C.C. 374 involved a claim that a surgery

center, which had submitted a facility fee billing in connection with an outpatient surgery, was unaccredited and unlicensed, and was thus not entitled to payment. The carrier had filed a civil action against two surgery centers alleging this, and at the time of the lien conference requested that the workers' compensation proceeding be stayed pending the outcome of the civil case. The Board refused, set the matter for trial, and eventually awarded fees to both surgery centers.

The Court of Appeals reversed, holding that the lien claimant had the affirmative duty of proving that it was properly licensed and accredited as required by the Health and Safety Code, and that in the absence of such proof, it was not entitled to fees.

Not discussed at the convention, but a case of interest which serves as an abominable blot on the judicial system is Universal Building Services v. WCAB, 8 W.C.A.B. Rptr. 10159 (April 27, 2006), where an outpatient surgery center billed $23,795.00 as the facility fee for an outpatient shoulder arthroscopy. At the lien trial, a bill reviewer from Strata Care testified with respect to comparable fees charged by 5 hospitals in the area (presumably, a comparison of inpatient fees), and the trial judge, in disallowing the balance of the lien, found the surgery center's charges to be "outrageous". One can only speculate at what the WCAB panel which reversed the trial judge and allowed full payment of the lien was thinking (or, perhaps, more than likely they were incapable of any kind of rational thought) allegedly on the ground that there was no evidence of what a surgery center in similarly situated circumstances would actually accept. The most astounding thing about this opinion is the panel's agreement with the trial judge that the billing was "outrageous", an observation which makes their decision in direct conflict with the specific mandate of Labor Code § 4906 to the effect that no lien shall be allowed, except in a reasonable amount (and if a judicial body believes that a billing is outrageous, then it can not possibly find that it is reasonable). At a

time when many surgery centers were finally beginning to get the message that their outrageous facility fees were no longer going to be tolerated by the Board, the entire community can give thanks to the commissioners involved in this particular decision for continuing to encourage these pirates to continue to plunder the system.

Marginally related to lien claims is In the Matter of John Hoffman, Jr., 71 C.C.C. _____ (May 17, 2006), involving the lien claim representative who appears to have been the head of Hoffman & Associates. It turns out Mr. Hoffman was an attorney who resigned from the state bar in the face of disciplinary proceedings which likely would have led to his disbarment, but continued to represent lien claimants before the Workers' Compensation Appeals Board on the theory that lay representatives were allowed to appear before the Workers' Compensation Appeals Board. The Board rules with respect to suspended or disbarred attorneys are somewhat restrictive, requiring such persons to obtain permission from the Board to represent parties before it, and Hoffman did not. Since this was the case, Hoffman was barred from representing any party, including lien claimants, before the Board. In fact, the Board actually questioned its own rule which allowed such an individual to represent parties before it upon obtaining the Board's permission (but did not specifically hold the rule invalid, since Hoffman had not taken advantage of it), noting the Supreme Court's determination that, where a person had lost his right to practice law, the attempt by such a person to practice law actually constitutes a misdemeanor.

Also on the subject of attorneys is Meeks v. John Muir Hospital, 34 C.W.C.R. 106 (2006), which related to the calculation of attorney's fees in connection with the enforcement of an award (pursuant to Labor Code § 5814.5). In this case, a carrier refused to pay interest on an award, and applicant's attorney brought an enforcement proceeding coupled with a Petition for Penalties (and

his client did receive a 25 % penalty with respect to the interest payment). Based upon the total amount awarded, the Board awarded the attorney a $2.00 fee, and applicant's attorney complained, indicating that the fee awarded should have been based upon an hourly rate (similarly to those awarded pursuant to Labor Code § 5801 in connection with frivolous appeals). The WCAB panel agreed, and remanded the case on the ground that, in the absence of a statute referencing a percentage of recovery, the time spent must be calculated at a reasonable hourly rate. We tend to think this case would probably have application with respect to the award of any attorney's fee which is not specifically based upon a percentage of the recovery.

The cases of CIGA v. WCAB (White) and CIGA v. WCAB (Torres), 71 C.C.C. 139 (2006) represent what is probably a logical extension of the Karaiskos case. Karaiskos stood for the proposition that, following the settlement of the case, CIGA had no liability to the Employment Development Department for a State Disability lien since the Employment Development Department's lien was a claim by the State, and was thus not a covered claim as defined by Insurance Code § 1063.1 (c)(4). White/ Torres involved the adjudication of an EDD lien in connection with the case in chief (i.e., could the lien be allowed as a part of a Findings and Award in connection with all issues). The Court of Appeals found that the EDD lien still constituted a claim by the State, and was still not a covered claim. Thus, CIGA had no liability.

What is perhaps truly depressing is Miceli v. Jacuzzi (Remedy Temp), 71 C.C.C. ____ (May 12, 2006), which was the remand following what can only be characterized as an abdication of judicial responsibility by the State Supreme Court. Miceli involved a claim by CIGA that, in the context of general and special employment, where CIGA assumed responsibilities for the general

employer's insolvent workers' compensation carrier, the workers' compensation carrier of the special employer constituted other insurance within the meaning of Insurance Code § 1063.1 (c)(9). Hundreds of cases were tied up in this consolidated litigation and hundreds of others were probably deferred awaiting the decision, while the case took years to wind itself first through the Board, and then up into the Appellate Court. While the decision of the California Court of Appeal (on re-hearing) might not have been entirely satisfactory to the workers' compensation community at large, it did, at least, provide some guidance and, if the Supreme Court was going to take any action at all, it was imperative that any action it took gave some guidance to the community with respect to the hundreds of cases which had awaited the outcome of this decision for so many years. Instead, the Supreme Court elected not to hear the matter (within its prerogative), and then directed that the Court of Appeal decision be erased, which had the effect of wasting the time, effort, and energy of everyone involved in this case from the attorneys and trial judge on up. The outcome of the case itself was not so important as the need for judicial guidance and, in this respect, the Supreme Court completely failed the community.

On the issue of penalties, McCarthy v. WCAB, 71 C.C.C. 16 (2006) confirms that the new penalty provisions of Labor Code § 5814, as amended by SB 899, applies to all claims of penalties adjudicated after the effective date of SB 899, even where the award of penalties was made prior to the effective date of the repeal of the prior section (January 1, 2005, although the legislation stated that the former section was inoperative as of June 1, 2004). Essentially, the gist of the opinions being made on this subject is that, if the award of penalties did not become final prior to the effective date of SB 899, the penalty claim was going to be subject to the new statute.

Also in connection with penalties, however, is a very recent case which was not discussed at the convention, but which is certain to warrant some attention: All Tune & Lube v. WCAB, 8 W.C.A.B. Rptr. 10179 (2006). This case stands for the proposition that the multiple penalty is not dead, even under the new statutes and, if the court deems the conduct upsetting enough, the penalties can be quite hefty. This case involved a 100 % total disability award, coupled with a need for home health care, transportation service, and a seeing eye dog, among other things (the industrial accident rendered applicant blind). There were repeated failures to make reimbursements, provide home health care, and late payments, even in the face of several Compromises and Releases with respect to obligations for past medical benefits, and post Award agreements to provide certain benefits, which were never provided. A total of six penalties (3 of which were at the $10,000.00 maximum, and the rest of which were at the 25 % maximum), plus awards of attorney's fees and sanctions pursuant to Labor Code § 5813 were the result. We suspect that the judge was of the opinion that the problems here were the result of something more than mere negligence.

City of Stockton v. WCAB (Jenneiahn), 71 C.C.C. 5 (2006) involved the attempt by a police officer to stretch the concept of a department requirement that he stay in shape to a rather ridiculous extreme. Applicant was injured during the course of a pick up basketball game which had absolutely no connection to the employer, and while applicant was off duty, but attempted to argue that he participated in the basketball game because of his employer's general requirement that he had to stay in shape. The court properly noted that a mere belief on applicant's part that his participation in general, off the job sports activity was good for his health was insufficient to establish an employment nexus.

California State Automobile Association v. WCAB, 71 C.C.C. 347 (2006) involves the ever recurring problems of unlicensed contractors being hired by a residential homeowner to do home improvements. In this case, applicant, who was unlicensed, was hired by the homeowner to paint his house, and was injured when he fell from a ladder. Applicant argued for coverage pursuant to Labor Code § 3352 (h), which defines residential employees as those being hired by the owner of a residence for the purpose of performing personal services, but also requires that such an employee must work a minimum of 52 hours, and earn at least $100.00 during the 90 day period preceding the injury, requirements which applicant did not meet. Since Labor Code § 3352 did not apply, the Board attempted to apply Labor Code §3715 (b) although it is somewhat unclear how the Board differentiated the requirements of this section from Labor Code § 3352. The decision was reversed in any event, finding that Labor Code § 3715 only applies to uninsured employers. The case is not quite final, since applicant has apparently requested a hearing before the California Supreme Court.

VII.

CONCLUSION

It appears the applicants' bar, to an extent, has accepted that the requirements of SB 899 may be here for some time, and has now resolved to grapple with the requirements of this legislation on the merits. Although we do not anticipate seeing attempts to use vocational evaluators in all cases, we do assume that the cases involving more significant disabilities will see more frequent use of this type of expert (although, interestingly enough, the Navarro case referenced above actually involved a relatively small amount of disability, no matter how the case was rated, which, of course, may have been one reason why the defendant elected not to appeal the decision).

We also suspect that we will be seeing more and more frequent attempts to bring in secondary disabilities, especially where the primary injury is orthopedic, for the purpose of attempting to maximize the dollar value of the permanent disability claim.

Finally, although the panel QME system has been in place for quite some time with respect to unrepresented workers, there was really not much focus on it from applicant's attorneys until now, but the new system, involving it as it does the use of panels for represented workers as well, has served to focus attention on the procedural requirements. Quite frankly, the convention delegates appear relatively confident that there are enough procedural requirements with respect to the use of these panels to enable them to find at least some defect in the manner in which the panel was requested, appointed, the manner in which the physician conducted the evaluation, and the manner in which the physician communicated his findings, that they will be able to force the appointment of multiple panels and obtain multiple evaluations, if they believe the need arises.

Significantly, applicants' former pessimism with respect to financial survival appears to have ebbed. Overall, we suspect that the system is about to become extremely complex.

Any of us will be more than happy to address any questions, comments, criticisms, and/or supplements which any of you may have at any time. Feel free to call us any time or, if you prefer, we would be more than happy to do a seminar or program for you.

Until the next convention, for the firm

BENTHALE, NICHOLAS & McKIBBIN

By: MICHAEL K. McKIBBIN
Attorney at Law

MKM/bev

2006 WINTER CONVENTION OF THE
CALIFORNIA APPLICANT ATTORNEY'S ASSOCIATION
RANCHO MIRAGE, CALIFORNIA
JANUARY 26, 2006 - JANUARY 29, 2006

TO OUR CLIENTS:

As has become our tradition, we are reporting on our attendance at the semi-annual convention of the California Applicant Attorney's Association held this winter between January 26, and January 29, 2006, in Rancho Mirage California. The character of the convention has certainly changed over the past few years. A few years ago, the convention was characterized by near hysteria (during the course of events leading up to the adoption of Senate Bill 899), with subsequent conventions being characterized first by shock and then disbelief, developing into anger, hostility and defiance, and then simmering.

This convention was actually somewhat subdued, although not as pessimistic (or even desperate) as some of the recent conventions have been.

The problem with wholesale changes of the legal system in a relatively short period of time is that long-term consequences may not be entirely thoroughly considered. To an extent, we saw that with the presumption in favor of the treating physician. In connection with that presumption, it was believed that, since the employer had the first thirty (30) days of medical control, most of the minor injuries would be discharged within that period of time and the defense would then have a presumption that nothing further was needed. The problem was that the presumption was not really needed with respect to most of the minor injury cases which amounted to nothing more than medical only claims. Those individuals who were serious about going out on disability, however, were pretty much consistently able to extend their disability beyond the thirty days and into a free choice, after

which the employee's doctor obtained the benefit of the presumption. In fact, real serious litigants obtained attorneys almost as quickly as they first saw the doctor, and those attorneys took advantage of various code provisions to thwart even the thirty day control period. As we all know, medical care in a litigated case many times was completely out of control. As a result, permanent disability ratings inflated as many judges took the position that if an applicant's treating doctor had a pulse, he was presumed correct.

Based on what we saw at this convention, applicant attorney's may be on to something again. At the last convention, they introduced a theory that the AMA based Permanent Disability Schedule could be circumvented by reference to vocational based testimony on applicant's loss of future earning capacity. That theory has been developed and fine-tuned over the last six or seven months, and several cases have now actually been tried on that theory. We suspect we will be seeing the results by the next convention, but, quite frankly, the arguments are making sense. The unfortunate effect of this, however, is that things may become very complex in workers' compensation. Up to this time, the primary experts were the doctors, but with the litigants' control over this aspect of the evaluation process having been somewhat limited by the new Qualified Medical Examination rules, we are going to see a new breed of expert with much greater frequency, that being the Vocational Evaluator, whose job, at least from the applicant's perspective, is to convince the judge that the presumptively correct Permanent Disability Schedule does not accurately or adequately take an injured worker's true disability into consideration.

Since this is the most fascinating aspect of what is currently happening in workers' compensation, we will cover that, along with other topics of interest.

I.

DISABILITY EVALUATIONS

The old Permanent Disability Schedule was based upon an employee's diminished ability to compete in the open labor market (Former Labor Code § 4660). As of January 1, 2005, the new Schedule replaces this criteria with a new one, that being the employee's diminished future earning capacity (Labor Code § 4660[a]). In fact, the Permanent Disability Schedule actually states (at pages 1-2) that:

> *"A zero percent rating signifies no reduction of earning capacity, while permanent total disability (essentially 100%) represents a level of disability at which an employee has sustained a total loss of earning capacity."*

This, of course, seems to suggest something different than 100% impairment under the AMA Guides to Impairment, in which 100% whole body impairment is, essentially, death. Labor Code §4660(b)(2) states that:

> *"An employee's diminished earning capacity shall be 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."*

The Section goes on to state that the Administrative Director was to formulate the rating schedule based upon the December, 2003 RAND Study, and upon data from additional empirical studies. (The argument is that this additional empirical study was actually the 2005 RAND Study, referenced below). Applicant's attorneys have complained for a long time that, in The Administrative Director's rush to timely implement the Permanent Disability Schedule, the future earning capacity modifiers contained in the new Schedule were nothing more than pure speculation; the Association actually characterizes the Schedule as being based upon the assumption that the applicant is actually capable of returning to something close to his usual work. Thus, the Association believes that the

new Schedule is actually more susceptible to attack than the old Schedule because they believe the premises upon which is it based (primarily, loss of future earning capacity) are faulty.

The Association believes and argues that the 2005 RAND Study is actually incorporated into Labor Code §4660(2), by its reference to the 2003 interim RAND Study, and "data from additional empirical studies." Among other things, the 2005 RAND Study states at page 100 that factors to be considered in determining a loss of earning capacity are a worker's age, education, prior work experience and other additional factors including job opportunities in a given location.

The new Rating Schedule specifically incorporates the AMA Guidelines, which also includes the first two chapters. It is in the these first two chapters that applicant's attorneys are focusing. Among other things, the guides in those chapters state that the impairment ratings are not intended for use as direct determinants of work disability, acknowledging that whole person impairments in the 90% to 100% range generally mean the person is near death (page 5), and that physicians' reports should include work histories with chronological descriptions of work activities, duration and materials used, and, if requested, the physician should analyze job tasks to determine whether applicant has the residual function to perform those activities. It even suggests the use of vocational experts (page 14).

Thus, there is certainly a suggestion in these first two chapters that the raw impairment percentages are expected to be subject to modification. At least in the case of California Workers' Compensation, that modification is the employee's loss of future earning capacity.

It is argued that the empirical data upon which a finding of lost earning capacity is made is based upon observation and experience rather than scientific data and that the following criteria needs to be taken into consideration in determining this (as RAND noted, the loss of future earning

capacity is much like wage loss): An applicant's ability to return to his usual and customary occupation; an applicant's education; an applicant's prior work experience; an applicant's language barriers; and whether the applicant is functionally restricted from various types of work. Unfortunately, no one can really explain how these factors are taken into consideration within the future earning capacity variances which are present in the new Schedule.

Which brings the Association to its point: Like the old Schedule, the new Rating Schedule is only *prima facie* evidence of the percentage of permanent disability (Labor Code §4660(c)). In essence, it is a rebuttable presumption and is not conclusive. In the early case of *Pence v. I.A.C.*, 30 CCC 207 (1965) the California Supreme Court held that there is a due process constitutional right to present evidence in rebuttal to a rating. In *McClune v. WCAB*, 63 CCC 261, the Court basically held that the liberal construction provisions of the Workers' Compensation Act compel developing the record. Thus, the purpose of the vocational evaluator's testimony is to present expert testimony for the purpose of rebutting the *prima facie* evidence set forth in the rating Schedule (Evidence Code §602 states that a Statute providing that something is *prima facie* evidence of a fact establishes a rebuttable presumption in favor of that fact).

To rebut the presumption, expert testimony is needed (experts are defined in Evidence Code §801 as essentially being those witnesses who are capable of rendering opinions on subjects which are beyond the common experience and who have special knowledge, skill, experience, training and/or education in the particular subject). The legal principle upon which the Association will rely is the principle that *prima facie* evidence can be rebutted when it is shown that the rating established by the Schedule does not accurately reflect the true disability. *Glass v. WCAB*, 45 CCC 441 (1980); see also *Universal City Studios v. WCAB*, 44 CCC 1133 (1979) (the percentage of disability obtained

from the Rating Schedule is only *prima facie* evidence of permanent disability and is not absolute, binding, and final); Chevron v. WCAB, 65 CCC 922 (2000) (writ denied) (the disability rating must be rationally related to the disability, and testimony of a vocational expert in this case was used to increase the mechanical rating of 10% to 45%).

Although used in other contexts, the most widely recognized situation where the *prima facie* evidence of disability established by the Rating Schedule is overcome is in the so called LeBoeuf cases (see Le Boeuf v. WCAB, 48 CCC 587 (1983); Gill v. WCAB, 50 CCC 258 [1985], where the Court rejects a scheduled disability rating in favor of a much higher one based upon extrinsic, expert evidence to the effect that an applicant is infeasible for rehabilitation and thus precluded from participation in the open labor market. These cases do stand for the proposition that vocational expert testimony is admissible for the purpose of rebutting the *prima facie* showing in the permanent disability schedule (although the vocational testimony certainly dovetails with supporting medical testimony).

The idea is that the vocational testimony will be tailored more to an individual injured worker's specific situation, referencing the Labor Code §4660(b)(2) direction that long-term loss of income should be referenced with respect to each type of injury for "similarly situated employees." The argument is that the permanent disability schedule is general, while the expert analysis will be applicant specific focusing on the applicant's ability to return to his usual and customary occupation, his education, his prior work experience, language barriers, work restrictions (and this is where the medical evidence dovetails) and other relevant data (transferrable skills, prior and future wage history, job stability, intelligence, etc.)

An example used were similar injuries (a failed post-surgical back) occurring to a bank president on one hand and a heavy construction laborer with limited education, on the other. As a practical matter, with such a physical injury, the bank president would be able to perform his work with little handicap and no real loss of income. On the other hand, the heavy construction laborer would be permanently foreclosed from his occupation and given his educational limitations, his future earning capacity would be devastated. Yet, the permanent disability schedule essentially treats both injured workers the same (a maximum impairment rating of 29%, modified by an identical future earning capacity variance, and with only a minor variant based upon the respective occupations). The argument here is that the Schedule does not even begin to measure the actual loss of future earning capacity sustained by the construction worker and this argument, quite frankly, has a lot of appeal.

The question is whether the same type of evidence could be presented to show that the disability set forth in the Schedule, at least with respect to the bank president (who retains his ability to perform his ususal and customary work, together with his half-million dollar salary, despite his back injury) could be used to decrease the rating which would be available under the new permanent disability schedule. The Association is quite hostile to this idea, but, quite frankly, we think it works both ways, (although we think that the absolute minimum to which such a rating would be reduced would be the actual impairment rating, which would then be adjusted for age and occupation without a future earning capacity adjustment).

Applicants' attorneys are looking to some authority out of state, one of the citations being an Arizona Supreme Court Case, *Slover Masonry, Inc. v. Industrial Commission of Arizona*, 761 P. 2d. 1035 (1988), where expert testimony was allowed from a Labor Market Consultant (also in

conjunction with supporting medical opinion) to the effect that the Arizona Schedule, based upon the AMA Guides, did not adequately reflect applicant's impairments in terms of his job functions. While *Slover* certainly appears to support the Association's position, we don't really think applicant attorneys' are going to have to go too far to convince judges that this type of evidence is allowable.

We think the primary concern from the defense standpoint is how often we are going to see this type of evidence, once it becomes established. There were panelists who were suggesting they might consider using this type of evidence in every case but, to be reasonable, we think this type of evidence is going to have to be type specific. In other words, in the garden variety sprain/strain cases, where medical science and the Guides contemplate a pretty much full recovery, legitimately, there should not be much loss of future earning capacity and we think we would be in a position to argue that the use of vocational expert testimony in such as case is abusive and unreasonable. These arguments are going to have to be made since the Association thinks it could make a very good case for establishing that the costs of retaining a vocational expert are recoverable costs under Labor Code §5811. In *Whitley v. Diamond International Corporation*, 13 CWCR 97 (1985), the Court supported applicant's right to be reimbursed for expert costs in a *LeBoeuf* case pursuant to Labor Code §5811 in the same manner as medical-legal costs under Labor Code §4600 (the Court also noted that the determination of permanent disability in such a case required a consideration of both vocational and medical factors). The costs here are not insignificant. Panel participants were estimating costs ranging from $900 (for what is essentially a simple vocational evaluation in preparation for trial testimony, with hourly rates for trial and/or deposition testimony), up to $4,000 for a life care plan.

One of the first reported cases with respect to the recent use of a vocational expert involved the attempted bushwhack of the defendant in *Grupe Company v. WCAB (Ridgeway)*, 70 CCC 1232

(2005), in which the Court of Appeal inexplicitly held that applicant's disclosure of her intent to use a vocational expert for the first time on the Mandatory Settlement Conference Statement (even though the expert had not yet even met with applicant) was permissible, and the expert's testimony should not have been stricken, since the rules relating to Mandatory Settlement Conferences did not require a disclosure of the type of testimony which would be given. This, of course, is a complete perversion of due process, although the Court allowed that it would be appropriate for the Board to reopen discovery under these circumstances if the Board suspected a "sandbag." How this was not blatantly obvious to everyone involved continues to suggest that applicants certainly maintain a rather favored position at the Board compared to the defense.

This realization on behalf of the Association was echoed by a panelist who suggested that, while his vocational expert would be free to review applicant's entire medical record, unless applicant's specific authorization was obtained, he would consider the submission of medical reporting to the defense vocational expert to be in violation of the Medical Privacy Act, the suggestion being that he would be able to have a fully prepared expert at trial, while the defendant would not. Of course, this would again appear to be a blatant violation of due process, and we would hope that most fair-minded judges would prohibit an applicant's attorney from getting away with something like this. We note cases such as *Hardesty v. McCord and Holdren*, 41 CCC 111 (1976), actually work both ways (each party to a workers' compensation proceeding must make available to the other party for inspection all non-privileged statements) and might be used to force applicant's to disclose the reporting of their experts (we would object to expert testimony which is not supported by a report which can be examined). These various discovery maneuvers are certainly new and in

order to be prepared with respect to what applicant's are planning, we need to start making plans with respect to how we will discover their information.

While we certainly do not think that, in the end, reasonable judges will allow applicant attorneys to get away with one-sided expert presentations, the situation is a Pandora's Box for the defense. We are faced with what may be a terrible dilemma: One, we can place total reliance on the new Permanent Disability Schedule, in which case the defense would not utilize an expert witness, would thus not have a rebuttal to applicant's expert. If we were to use an expert witness (the second alternative), in most circumstances, we think our own expert witness would probably take the case out of the permanent disability schedule and into the realm of vocational evaluation. We say this because the focus of applicant attorney's cross examination of the defense expert may not be so much with respect to the individual applicant's loss of future earning capacity, but will be with respect to that expert's understanding of the method by which the new Permanent Disability Schedule evaluates the loss of future earning capacity. The panelists who have conducted such cross examinations have reported that the defense experts concede that the Schedule's future earning capacity variants do not really appear to be rationally based and certainly did not appear to be tailored to employees who are similarly situated. That type of testimony from a defense expert, of course, rebuts the presumptive correctness of the new Permanent Disability Schedule.

Off the subject of vocational evaluators, but on the subject of evaluating cases, are the problems associated with obtaining medical information in connection with the determination with respect to whether to admit or deny a case. The time constraints are brutally short, assuming medical information is needed. The traditional route is pursuant to Labor Code §§4060 and 4062.2, which almost requires immediately putting into effect the utilization of either an Agreed Medical Examiner

or a Qualified Medical Examiner, if a carrier/employer hopes to have medical reporting prior to the expiration of the ninety (90) day investigatory period. There are only a few Agreed Medical Examiners around (Roger Sohn, M.D. is one), who have a special examination mechanism in place for Labor Code §4060 evaluations, whereby the evaluations and reports are expedited. Most Agreed Medical Examiners take months just to do the evaluation, so an Agreed Medical Examination is not really a viable alternative in a Labor Code §4060 setting. Even utilizing the Panel Qualified Medical Examiner (which, to a certain extent, almost represents the kiss of death) pretty much requires immediate action almost from receipt of the claim so as to ensure the report is received prior to the end of the ninety (90) day period.

We think there may be another way, although it is certainly a bit chancy. We note that Labor Code §4050, allowing evaluations at the request of the claims examiner, remains in effect. It is true that the reports resulting from these evaluations would not be admissible in a workers' compensation litigation, but it is possible that the carrier would be entitled to rely upon the results of such an evaluation report to make an investigatory decision with respect to whether to admit or deny the claim. Carriers seem to agree that the primary problem with respect to showing whether or not an investigation is in good faith is isn't with the Workers' Compensation Appeals Board, but with OBAE, and while the Labor Code §4050 report might not be admissible in a WCAB proceeding, there is nothing of which we are aware that dictates that the report would not be usable to support a carrier's action during the course of an OBAE audit. Food for thought.

II.

SCHEDULED ALTERNATIVES TO TRADITIONAL INJURIES

The Association's focus in attempting to circumvent what they believe to be the unwarranted reduction in disability with respect to traditional injuries by the AMA Schedule is not restricted to attempt to circumvent the Schedule itself. To an extent, the AMA Guides, at least with respect to certain types of impairments, create possibilities to resurrect disabilities that were previously thought minimized. One of the most significant effects of the AMA Guides was to pretty much eliminate significant disability based on pure subjective complaints of pain, with the Guides essentially providing that the percentages with respect to specific types of disability took into consideration the normally anticipated subjective complaints with respect to that disability. In those cases where subjective complaints were clearly believed to be in excess of that which would be normally anticipated there was a provision for an additional 1% to 3% allowance.

The community initially felt that the most significant impact of this change would be on the so called pain syndrome cases, especially the so called fibromyalgia cases.

Although prominent physicians have found significant, indeed total, disability in fibromyalgia cases, and a lot of disability money has been spent in connection with these cases, the defense community has always been skeptical of the syndrome, with many of us viewing it as a justification for otherwise unsubstantiated disability (one prominent Agreed Medical Examination quality orthopedic surgeon referred to it as "voodoo"), and indeed, malingering.

It may be that the fibromyalgia type disabilities are not quite as dead as we would like to think. Instead of focusing on the syndrome as a whole (or even characterizing it as being subjective) the syndromes are now being characterized as being essentially central nervous system disorders and

it appears that the focus now is going to be on certain aspects of the symptom complex, which aspects are recognized by the AMA Guides as causing actual impairments.

At least several of the prominent Agreed Medical Examiners with respect to fibromyalgia cases (Rodney Bluestone, M.D., is one) have been of the opinion that one of the hallmark symptoms of fibromyalgia has been sleep interference. Several of the medical panelist stress the differentiation between "acute pain" (basically characterized as beneficial, since it is a triggering device which warns the body against additional injury) and "chronic pain" (an actual disease process which develops when pain persists beyond the acute stage). This chronic pain interferes with the sleep process, and the effects of the resulting interference then tend to more acutely exacerbate the feelings of pain, which tends to cause more interference with sleep, etc. Sleep disturbance studies have apparently concluded that the greater the amount of sleep deprivation, the lower the pain threshold and the result is somewhat a vicious cycle.

It is noted that the AMA Guides (Table 1-2) does list sleep as one of the primary activities of daily living which are taken into consideration in determining impairments. The panelists suggested that the two most common forms of sleep disturbances are sleep apnea (which actually appears to be a combination of sleep/respiratory disorder) and insomnia (it is apparently thought that the sleep deprivation can result in forms of narcolepsy to various degrees, essentially involuntarily falling asleep; the hallmark of a sleep impairment under the AMA Guides appears to be a reduction in daytime awareness.) The impairment ratings range anywhere between 1% and 90%, depending upon the effect of the sleep disorder on a person's daytime awareness and, while there are probably not many fibromyalgia cases where the reduction in daytime awareness is so acute that an individual is unable to care for him or herself in any situation or manner (the hallmark of a 70% to 90% case),

we will certainly see claims that the applicant's ability to perform activities of daily living is significantly limited (the hallmark of a 30% to 69% case; the reason for the extensive range is that the Guides cannot predict the exact effect of the disorder on any particular individual, so the exact rating will be determined on a case to case basis) (See Table 13-4, AMA Guides). Example 13-19 (Guides page 318) describes a person who experiences multiple daily episodes in which the urge to nap is irresistible and the diagnosis is narcolepsy, which brings this person to the 39% impairment threshold.

Possibly to be used in combination with sleep disorders (when dealing with a fibromyalgia type case) are the so called somatoform pain disorders where it is explained that a mental illness may distort the perception of pain, making it part of a somatic delusion in an individual with a major depression or a psychotic disorder. In such as case, pain may become the object of an obsessive preoccupation (AMA Guides, page 366). In these circumstances, the pain is actually a component part of a mental or behavioral disorder, and is rateable as such (the new Schedule provides that such disorders would be rated on a global assessment of functioning (GAF) scale which would certainly be an appropriate method of evaluating an impairment if the pain delusion interfered with an applicant's activities of daily living).

To a very large extent, applicants will be looking to more esoteric type claims (many of which, to some extent, are associated with pain disorders) in connection with their attempts to boost ratings not only in the purely subjective type cases, but also with respect to some of the more traditional, but serious orthopedic cases as well (and if they are successful in doing this, it provides an alternative to attempting to circumvent the Schedule by way of a vocational evaluation). Thus, different impairments at which applicants will be looking will be diabetes (stress aggravated, Table

10-8); heart disease and arrhythmia (Tables 3-6a and 3-11), hypertension (Table 4-2); upper digestive tract disorders (e.g. GERD, Table 6-3); colonic and rectal disorders (Table 6-4); skin disorders (Table 8-2); and a disorder which some applicant attorney's are now routinely putting on their Applications, a white blood cell disorder (Table 9-3). (We're still not quite sure how this works. There's a suggestion that white blood cell elevation can confirm the existence of pain. That doesn't seem to be the impairment that the Guides address - the impairment here appears to be actual white blood cell disease, such as leukemia and or HIV, which suggests a toxic exposure). All of these impairments can result in surprising high ratings.

III.

APPORTIONMENT

Based on our reporting from the last convention, resolution of apportionment issues seemed to all be going in the favor of the defense. It was held that apportionment would be based upon causation (with attribution to pathologic degenerative processes, assuming there was substantial evidence to support it) (*Escobedo v. Marshall's*, 70 CCC 604 (2005), and apportionment was to be applied by the percentage subtraction method set forth in the old Supreme Court Case of *Fuentes v. WCAB*, 41 CCC 42 (1976) (*Nabors v. Piedmont Lumber and Mill Company*, 7 CCC 956 [2005]).

That train has perhaps derailed. A Petition for Writ of Review has been granted in *Nabors*, and an almost identical case was decided by the District Court of Appeals in *E & J Gallo Winery v. WCAB*, 70 CCC 144 (2005). In *Gallo* (also known as *Dykes*), the Court held that *Fuentes* was no longer controlling law, since the decision in *Fuentes* was expressly based upon language in former Labor Code §4750, which stated:

"The employer shall not be liable for compensation to such an employee for the combined disability, but only for that portion due to the later injury as though no prior disability or impairment had existed."

The Court observed that former Labor Code §4750 was repealed in connection with the adoption of SB899 and essentially replaced with new Labor Code §4663 and §4664. It noted that, in the case of a prior Award, §4664 states that the prior disability was conclusively presumed to exist and that the employer would only be liable for the percentage of permanent disability directly caused by the injury at issue and, keeping the liberal construction mandate of Labor Code §3202 in mind, this Statute compelled a result that the dollar value of the case would be determined by the overall level of disability, with the employer receiving a credit for the amount of money paid in connection with the prior disability.

The *Gallo/Dykes* Case involved a long term Gallo employee who sustained a 1996 back injury for which he received a 20½% permanent disability award. He continued working until sustaining a second back injury on October 28, 2002, and his overall disability following that injury was rated at 73%. The defendant argued for *Fuentes* type apportionment, which would have reduced applicant's industrial disability with respect to the 2002 injury below the life pension to 52½%. Instead, the Workers' Compensation Judge awarded the 73% disability (which, of course included the life pension) and allowed an $11,680 credit to the defendant for the permanent disability money previously paid in connection with the prior 20½ % Award. Reconsideration was denied, and the result was affirmed by the Court of Appeal. The Court indicated that its decision was essentially limited to the type of case which was actually before it (a situation where an employer received multiple disability awards as a result of injuries with the same employer), and indicated that it was not expressing an opinion with respect to whether its rationale should be applied where an employee

received a prior disability award from another employer, where the apportioned disability was non-industrial, or even where the employer was separately insured at the time of each of the injuries. However, the rationale used by the Court of Appeal, if upheld, would certainly seem to make irrelevant the fact that there were different insurance carriers for the same employer at the time of various disabilities (insurance carriers do nothing more than step into the shoes of the employer in any event), and the rationale would certainly appear to have equal application to a situation where an employee has sustained multiple industrial injuries with different employers (after all, Labor Code §4664 does not differentiate between employers; it applies generally to Awards issued in connection with industrial injuries).

The most convincing exception to the rationale from the defendant's standpoint is probably a situation where the apportioned prior permanent disability is non-industrial. In such a case, the Court's underlying rationale, i.e., that an employee should be fully compensated for the full amount of his industrial disability, rather than being shortchanged by artificially cutting up multiple industrial injuries into segments which require far less compensation, does not really apply.

One of the panelists, Judge Mark Kahn, when asked how he anticipated judges would handle the *Gallo* decision, advised he anticipated that the rationale would probably be applied in all apportionment cases, no matter what the source of the apportionment.

We understand a Petition for Review is pending with the Supreme Court, although there has apparently not been any action with respect to it.

Unfortunately, all the other cases in the pipeline to the various Courts of Appeal with respect to this or similar issues (*Nabors; Strong v. City and County of San Francisco*, 7 CCC 1460 [2005], involve the same employer and thus give the various Courts of Appeal the opportunity to simply

affirm the *Gallo* ruling assuming the decisions are the same. It may be that the Supreme Court will refuse to visit the issue (assuming it agrees with the rationale, although the fact that the District Court of Appeal has rejected a Supreme Court Case may raise the Court's interest) until a case with different facts comes along (industrial injuries with different employers, or prior non-industrial apportionment). We will see.

The other significant case is *Sherman v. Los Angeles Unified School District*, (citation currently unavailable, which suggests it may not be in the CCCs, but will probably appear elsewhere) (October 28, 2005), which addressed the issue that *Escobedo* indicated it was not addressing: The situation where a prior non-symptomatic pathological condition is "lit up" by an industrial injury. In *Sherman*, applicant had an underlying rheumatoid arthritis condition which was asymptomatic, although, apparently, there was no reasonable indication if or when it would become symptomatic in the absence of the industrial injury. The Agreed Medical Examiner indicated that all of applicant's disability was the result of the rheumatoid arthritis, which had been lit up by the industrial injury, but concluded that, if not for the industrial injury, applicant would not have the disability. The Workers' Compensation Judge found no apportionment and reconsideration was denied.

A contrary result was reached in *Beery v. WCAB*, 70 CCC 1334 (2005), where it was found that apportionment was warranted in a "lighting up" case, apparently based upon the idea that the underlying disease was in part at least a cause of applicant's disability (probably a reasonable assumption). In this case, the defense Qualified Medical Examiner was apparently followed by the judge because despite the acknowledged existence of the underlying pathologic condition, applicant's doctor neglected to discuss it all, simply stating a conclusary opinion that there was

apportionment. The judge apparently took a black or white approach to the apportionment issue (maybe believing he had to), deciding that, if it existed, he had to rely on the defense report, since it was the only report that adequately discussed the issue. The panel speakers noted that the judge might not be so constrained, referencing *Gay v. WCAB*, 44 CCC 817 (1979), a case which stands for the proposition that a decision on apportionment may be based upon a range of the evidence (strange that applicants should be arguing this now).

Labor Code §4664(b) appears to contain a ridiculous inconsistency, on one hand, stating that a prior award of permanent disability is conclusively presumed to continue to exist while at the same time indicating that "this presumption is a presumption effecting the burden of proof." Either a presumption is conclusive or it is not; it cannot be both.

A couple of *en banc* decisions *Sanchez v. County of Los Angeles*, 70 CCC 1440 (2005) and *Strong v. City and County of San Francisco*, 70 CCC 1460 (2005), (a Petition for Writ of Review has apparently been filed in this case and is apparently pending) may actually make some sense out of this supposed contradiction, but not in the way applicant's attorneys prefer. The applicant attorneys, of course, prefer to harmonize the Statute in favor of a rebuttable presumption, but the *Sanchez* and *Strong* Cases suggest that the "conclusive presumption" section of the Statute means that, once defendant has satisfied its burden of establishing the existence of a prior disability award, an applicant is not entitled to produce evidence of medical rehabilitation for the purpose of lessening the apportionment; however, applicant is entitled to produce evidence on the issue of "overlap" (traditionally, a weapon of the defense), to the effect that the prior award involved permanent disability factors which are different from the factors of disability resulting from the present injury, (i.e., the applicant has the burden of showing that the prior disability effects a different ability to

compete and/or earn). Thus, in *Sanchez*, it was found there was no apportionment, since the Award in the prior case was based upon the limitation of activities, while applicant's permanent disability in the present case was based upon subjective complaints (presumably, different subjective complaints than were present at the time of the prior disability; we suspect that this rationale would apply to different types of work restrictions as well).

Another major concern of applicant attorneys' is the effect of filing a Petition to Reopen in the post SB899 environment. To a certain extent, this was addressed in *Marsh v. WCAB*, 70 CCC 787 (2005), a Court of Appeal Case involving a 1999 injury with a resulting Stipulated Award at 46%. A Petition to Reopen was filed and, during the pendency of the reopening proceeding, SB899 became law. Previously, the Agreed Medical Examiner had evaluated the applicant, and while he found an overall increase in applicant's disability (he felt applicant was now sedentary) he felt that the increased disability was caused equally by the industrial injury and a non-industrial condition, osteopenia. Reconsideration was granted and the judge was ordered to develop evidence on apportionment based upon the recently enacted Senate Bill 899. Quite frankly, assuming the Agreed Medical Examiner's opinion is supported by sufficient evidence, we see no reason why the increased disability (beyond the underlying 46% Award) should not be apportioned, and this case dealt with only the effective apportionment on the increased disability (rather than whether apportionment could be applied to the underlying Award itself, thus decreasing the amount of disability previously awarded. There is concern by the panelists that some defendants are claiming that, by filing a Petition to Reopen, the underlying award is no longer "final" within the meaning of §47 of SB899 [the provisions of SB899 are to be applied prospectively to all pending cases, except with respect to final orders]).

This, of course, raises all kinds of issues of *res judicata* and *collateral estoppel*, where, presumably, there is a long since final order which essentially finds that apportionment does not apply. Quite frankly, our opinion is that the argument that a Petition to Reopen basically exposes the underlying award to an apportionment argument is not going to find any favor with trial level judges and they, as well as the appellate bodies above them, will take pains to avoid such a result. In any event, there appears to be agreement that, if a defendant wished to challenge a prior award in this manner, they could not do it based upon the mere filing of a Petition to Reopen for New and Further Disability; the defendant would be required to file a Petition to Reduce (thus exposing itself to an award of supplemental attorneys' fees if it were to lose this Petition).

From a procedural standpoint, the judicial abomination known as *Rio Linda Union School District v. WCAB (Scheftner)*, 70 CCC 999 (2005), (standing for the proposition that an Order closing discovery following an Mandatory Settlement Conference was a final Order for the purpose of *§47* Senate Bill 899, thus precluding application of the new apportionment statutes in the subsequent trial) has been vacated. This essentially follows the line of reasoning in *Kleemanm v. WCAB*, 790 CCC 133 (2005) which indicated that §47 referred to a final adjudicatory decision and it was obvious that *Scheftner* involved nothing more than an interim procedural order.

IV.

MEDICAL TREATMENT

The protestations with respect to the employer's ability to control medical treatment through the use of the Medical Provider Network really doesn't seem to be as shrill now as it was in the past. While the Panelists still instruct members with respect to methods by which to escape the reach of the MPN, there does seem to be a growing approach on the part of at least some of the Panelists to

simply accept the MPN. One reason for this may be that a number of the MPNs are so large that many of the traditional applicant doctors are actually members and the availability of an unlimited free choice within the MPN to an extent gives applicants what they want anyway. To a certain extent, when an applicant ends up with his tradition applicant doctor in an MPN, the defendant is really at a disadvantage, as Regulation §9767.6 provides that the defendant is not entitled to request change of treating physicians from the Administrative Director under such a circumstance.

If an applicant is intent on escaping from the MPN, one of the focuses is going to be upon lack of notification. The notice requirements are generally contained in Regulation §9767.12, which require that, prior to the implementation of an MPN, at the time of hire or when an employee transfers to an MPN, written notice is to be given with respect to at least thirteen different subjects: how to contact the MPN; a description of MPN services; how to review, receive or access the MPN Medical Directory, how to access initial care and subsequent care; how to access treatment out of the area; how to choose a physician within the MPN; procedure to be used if an appointment cannot be obtained; how to change a physician within the MPN; how to obtain a specialist referral; how to use the second and third opinion process; how to obtain an independent medical review; a description of transfer of care standards; and a description of the continuity of care policy. Another point which applicants will consider will be access standards (as set forth in Regulation §9767.5, requiring what types of physicians are to be available and geographical convenience). The Association feels that a failure to comply with these requirements will entitle an applicant to free choice outside of the MPN.

To a certain extent, many applicants' attorneys almost prefer the situation where injury AOE/COE is denied, since there is going to be no authorized treatment within an MPN in such a

case. Under this circumstance, the applicant will free choice any doctor he or she wants, and is free to treat with this physician until the injury question is resolved one way or another.

Even in the case of an admitted injury, if there is no MPN, then an applicant is entitled to free choice of physician after the statutory control period.

Quite frankly, this puts the defense in a very frustrating situation. We think applicant's still have a tremendous advantage in connection with the generation and production of medical evidence. The reports of treating physicians are always admissible on the issue of injury AOE/COE and disability, and the only method by which a defendant can obtain a rebuttal opinion in a post January 1, 2005 case, is by way of an Agreed Medical Examination or resort to the Panel Qualified Medical Examiner process (basically a crap shoot).

Defendants only real control is through the timely use of the Utilization Review, and under the current state of the law, if the Utilization Review is not timely, the resulting Reports cannot be used for any purpose whatsoever. *Sandhagen v. Cox and Cox Construction*, 69 CCC 1452 (2004). *Sandhagen* prohibits the parties from even agreeing to submit late Utilization Review Reports to an Agreed Medical Examiner, a prohibition which appears to be unjustified, but since it forms a part of an *en banc* decision, it is binding. If the Utilization Review is untimely, *Sandhagen* does allow a resort to a timely objection under Labor Code §4062 (which begins the Agreed Medical Examiner process and/or resort to a Qualified Medical Examiner, panel or otherwise).

We note the very recent case, *Doctor's Medical Center of Modesto v. WCAB*, 8 WCAB Rptr. 10 005 (Dec., 2005) on the issue of Utilization Review, suggests that the Utilization Review Report is not substantial evidence in the absence of submission of the ACOEM Guidelines on which it is based (remembering that it is the ACOEM Guidelines that have the presumption of correctness, not

the Utilization Review Report). Thus, Utilization Review Doctors are going to have to make specific reference to the Guidelines of which they are referring and if the matter proceeds to litigation, a copy of those guidelines is going to have to accompany the report (the opinion is unpublished thus, technically uncitable, but applicant's will certainly be looking to follow its rationale). The argument, of course, is that in the absence of the guidelines, the Utilization Review Reports are not complete and, thus, do not constitute substantial evidence. Utilization Review Reports, like other reports, are required to be based on substantial evidence in order to have any weight. *Willette v. Au Electric Corporation*, 69 CCC 1298 (2004); *Smith v. Churn Creek Construction Company*, 32 CWCR 162 (2004).

Utilization Review remains a thorn in the sides of applicants' attorneys, and they suggest that they will challenge Utilization Review decertification at every opportunity. One basis for challenge will be a failure to timely serve Utilization Review Reports. The panelists suggest that this is the common, almost universal problem: Utilization Review Reports, whether favorable or non-favorable, are not served on the attorneys. Quite frankly, there is some truth to this assertion and it is a problem. We view Utilization Review Reports as medical reports which are required to be filed and served in the same manner as any other medical report. They are particularly critical when the effect of such a Utilization Review Report is to decertify a recommended course of medical treatment. When this occurs, Labor Code §4062 gives the aggrieved party (always in such a situation, the applicant) a limited period of time in which to object and, if applicant's attorney is not being served with a copy of the Utilization Review Report, this time period slips by and also gives rise to the argument that the failure of service has unnecessarily delayed potential medical treatment. The attorneys must be put on the mailing list for prompt service of the Utilization Review Reports

or we may find ourselves in a position where we cannot use those reports, even if they were performed in a timely manner.

One recurring issue is the situation where there is a conflict between the utilization review recommendation and the opinion of an Agreed Medical Examiner. We have long felt that, under these circumstances, the opinion of the Agreed Medical Examiner would prevail and that was the opinion of the Workers' Compensation Appeals Board in *Regents of the University of California v. WCAB (Rewald)*, 70 CCC 897 (2005) (Writ Denied). This case actually involved a treating surgeon's recommendation for a disc replacement surgery, a somewhat new and controversial procedure performed in lieu of a fusion (based upon our experience with such a recommendation, the proponents of such a procedure state that the disc replacement involves less recovery time and results in less impairment, such as lack of spinal mobility, than a traditional fusion). In *Rewald*, the Agreed Medical Examiner agreed with the surgeon, and indicated that the disc replacement surgery was a reasonable option. Interestingly, the Agreed Medical Examiner's Report was submitted to Utilization Review which decertified the recommendation, essentially on the ground that it was an experimental procedure which had not yet received full FDA approval (that has since changed). In allowing the surgery, the Board stated that an Agreed Medical Examiner's opinion is ordinarily followed, unless there is a good reason to find the opinion unpersuasive, citing *Power v. WCAB*, 179 Cal. App. 3rd 755 (1986).

Utilization Review has no persuasive force on the issue of injury AOE/COE. Thus, in *Simmons v. State of California*, 70 CCC 866 (2005), there was a recommendation for surgery and, although the Utilization Review Doctor agreed that the surgery was medically necessary, he questioned the industrial relationship of the medical treatment. The Board suggested that the

Workers' Compensation Judge erred in excluding the UR Report, since it was admissible for the limited purpose of establishing compliance with UR requirements and on the issue of whether treatment is within the guidelines; however, the Utilization Review Doctor has no standing to comment on the issue of industrial causation, so the surgery was allowed.

We do note that the parties continue to grapple with issues relating to the transfer of care from a non-network doctor to an MPN. We now appear to have some permanent regulations governing how this is to be accomplished. Obviously, the notice requirements imposed by Regulation 9767.12 apply, and Regulation 9767.9 governs the actual transfer itself. Notice is to be given to the employee (subsection f) and a copy of the notification must be sent not only to the employee, but also to the Primary Treating Physician (and if the employee is represented, we think representation rules require that a copy be sent to the attorney as well). If the employee disputes the employer's determination that one of four exceptions does not apply (acute condition, chronic condition, terminal illness, or performance of surgery, see Regulation 9767.9[e]), then the Treating Physician shall provide a report on the subject within twenty days of the transfer request. If the physician fails to issue the report, then the employer's transfer determination is enforceable. Regulation 9767.9(g).

Certain time lines have been changed. For example, an acute condition is now one that has a duration of less than ninety (90) days [changed from thirty (30) days] and there is some suggestion that the surgical exception may apply if it is a surgery contemplated to occur within one hundred eighty days (180) days from the MPN coverage date.

One additional note on the issue of medical treatment relates to the subject of Nurse Case Managers. In *Casotorena v. Liberty Mutual Insurance Company*, 32 CWCR 74 (2004), it was

decided that a Nurse Case Manager is a form if treatment contemplated by Labor Code §4600, so the applicant has a free choice right to select the Nurse Case Manager if it is determined that one is required.

V.

OTHER ISSUES

In connection with Appeals, Labor Code §5955 provides that only the District Court of Appeals and Supreme Court have jurisdiction to review decisions of the Workers' Compensation Appeals Board (and review is discretionary to boot). Under Rule 10840, a Petition for Reconsideration may be filed by a party within twenty (20) days of "service of any final Order, Decision or Award" and Rule 10859 provides that the Workers' Compensation Judge may actually pull back the Decision to amend, modify or annul it if he deems that appropriate. If the issue is deemed important enough, even if a party has not timely filed a Petition for Reconsideration, the Workers' Compensation Appeals Board, on its own motion, may grant reconsideration within sixty (60) days of the filing of the Decision pursuant to Labor Code §5900. The Petition for Reconsideration is denied if the Workers' Compensation Appeals Board has not taken any action upon it within sixty (60) days of filing pursuant to Labor Code §5909.

The next step is the Petition for Writ of Review directed to the District Court of Appeal and this filing must be done within forty five (45) days of the filing of the Opinion on Reconsideration pursuant to Labor Code §5950, *et seq.* The time is extended if the last day falls on a Saturday, Sunday, or Holiday (Code of Civil Procedure §12), and a party is required to include all relevant Exhibits with the Petition (at a minimum, the Order, Award or Decision reviewed, Minutes of Hearing and Summary of Evidence and the Report on Reconsideration must be attached). California

Rules of Court, Rule 57a. Most of these discretionary Petitions are denied; statistics show that over 80% were denied in the year 2005.

If the Court of Appeal issues a Decision on review which misstates an issue or a fact, a Petition for Rehearing is required as a condition precedent to Supreme Court review (Petition for Rehearing is permissibly allowed in the event that a new matter arises which can be judicially noticed). If the Petition is not granted before the Opinion becomes final, it is deemed denied. A District Court of Appeal Decision is deemed final at the time it is filed if it is a simple "writ denied" decision, or thirty (30) days after filing, if a full Opinion is filed (we assume that a Writ Denied Case, with a brief Opinion by the Court, probably qualifies as a "writ denied" case for the purpose of finality). In any event, a Petition for Review with the Supreme Court is to be filed ten (10) days after finality of the District Court of Appeals Decision (California Rules of Court, Rules 28, 44). Interestingly enough, there is no extension of time if the tenth day falls on a holiday.

The extent to which multiple industrial injuries will have a bearing on case value and/or multiple party exposure, is unclear. It is assumed that *Wilkinson v. Workers' Compensation Appeals Board*, 19 Cal 3rd 491 (1977), although growing out of the *Fuentes* Decision, still has viability since it was not itself based on former Labor Code §4750, but was rather an attempt to ameliorate what was considered to be the harsh effect of that section. Assuming *Gallo/Dykes* remains valid law, cases such as *Western Growers Insurance Company v. WCAB (Austin)*, 58 CCC 323 (1993), and *Aetna Casualty and Surety Company v. WCAB (Coltharp)*, 38 CCC 720 (1973), may not actually have an effect on the value of applicant's case so much as they will affect the exposure of the various carriers involved.

The Association continues to have some focus on investigation issues. *Hardesty v. McCord and Holdren*, 41 CCC 111 (1976), has long stood for the proposition that each party must make available to the other party all non-privileged witness statements in their possession. The rationale for this was explained in *Moreno v. City of Los Angeles*, 21 CWCR 108 (1993), observing that applicants' attorneys cannot afford to take the deposition of defense witnesses in Workers' Compensation Cases, a requirement which would be inconsistent with the approach to Workers' Compensation as being a relatively inexpensive method of securing compensation for industrial injuries. *Martin v. WCAB*, 62 CCC 1500 (1977), stands for the general proposition that statements of co-employees obtained by an investigator are not protected by the attorney-client privilege and, while it may be subject to a limited work product privilege, the privilege does not apply where the denial of discovery would unfairly prejudice the party seeking discovery (and the unfair prejudice, according to *Moreno*, is the burden of expense). *Hardesty* did provide that the investigators work product (in other words the investigator's statements and opinions to the attorney who obtained them) remain privileged, absent a very strong showing of prejudice. Our position is that while statements are generally discoverable upon demand, the narrative investigation reports are not, and we will withhold those in the absence of a court order.

We have all seen the medical reports from applicant's free choice physicians towards the end of 2004, whereby the physicians state that, although they want to continue treating an applicant for an indefinite period of time, and thus continue to find an applicant temporarily totally disabled, include a conclusory statement to the effect that an applicant will have permanent disability. An earlier case, *State Compensation Insurance Fund v. WCAB*, 69 CCC 579 (2004), did suggest that medical treatment can be evidence of permanent disability, for example, the use by applicant of

certain orthopedic devices which are contemplated to be required on a permanent basis; however, the mere statement that a doctor anticipates permanent disability, while an applicant remains on temporary disability and under continuing treatment, was found by a judge to not be substantial evidence in the *Vera* case (trial level), although a different result was reached at the trial level in the *Camacho* case (this one can apparently be found at 2000 Cal. Work Comp PD Lexis 47). As we understand it, both of these cases are on Reconsideration at this time.

A case which is also on Reconsideration is trial court Decision in *Elizabeth Aldi v. Carr, McClellan, Ingersoll, Thompson and Horn; Republic Indemnity*, Case SFO 0485703, where the judge determined, as a matter of law, that all injuries occurring prior to January 1, 2005, are rateable under the old rating schedule, for some reason seeming to find that the new rating schedule was not adopted within the time mandates of Labor Code §§4658 and/or 4660 (Labor Code §4660[e] indicated that the Administrative Director would adopt regulations on or before January 1, 2005, to implement the changes made by the Section [those regulations adopted the new permanent disability schedule]), and it appears that even the judge concedes the regulations were effective January 1, 2005.

The decision obviously is not binding authority, and we will see what happens on Reconsideration.

In *Farmer Brothers Coffee v. WCAB*, 70 CCC 1399 (2005), an employer contended that an illegal alien was not entitled to workers' compensation benefits, since the California Workers' Compensation Law was preempted by Federal Law prohibiting the employment of undocumented aliens. The Court found that the Labor Code defines employees as all persons in the service of the employer, whether lawfully or unlawfully employed, and found that the California policy of

compensating injured workers does not conflict with Federal Law prohibiting employment of undocumented workers. The Court pointed out that California Law does exclude a reinstatement remedy and back pay to an undocumented employee, which harmonizes the workers' compensation scheme with federal policy.

Jackson v. WCAB, 70 CCC 1413 (2005), dealt with the heart disease presumption set forth in Labor Code §3212.2, and the rule that the employer was capable of rebutting the presumption with proof of causation by a non-industrial event. In this case, involving a correctional officer, defendant established that applicant's death from heart disease actually began with an upper respiratory tract infection, that developed into bronchitis and that a virus resulting from this infection infected his heart, leading to the fatal heart attack. That was all fine and good, except the Court pointed out that there was no evidence that the original respiratory infection itself was non-industrial, so the death was found to be industrial.

Finally, the applicability of Labor Code §132(a) was considered as it related to the removal of an employee from his employment following an employer's knowledge of work restrictions which precluded performance of some of applicant's required duties in *County of San Luis Obispo v. WCAB (Martinez)*, 70 CCC (2005). This case involved a mental health therapist who, as a part of his job duties, was expected and required to physically restrain combative patients when necessary. He had a back surgery and received work restrictions which precluded him from performing this activity, even though he had returned to work and circumstances had not arisen which required him to engage in this activity. The Court found that, at the time of applicant's termination, the employer had become aware of work restrictions which justified the termination as a business necessity (a concern over increased harm to the worker) and that the employee was not only required to demonstrate detriment as the result of an employer's action to establish a case under Labor Code

§132(a), but must also show that he was singled out for disadvantaged treatment because of his injury. That was not done here.

VI.

CONCLUSION

It appears that the Workers' Compensation landscape is continuing to change. The observation of the number of people attending this particular convention is that the effort to establish compensable disability is bringing workers' compensation proceedings, at least from a procedural standpoint, closer to Superior Court litigation. There is going to be an increased focus on non-medical expert testimony, particularly in the form of vocational evaluators, in an attempt to circumvent the permanent disability schedule itself, balanced with claims by the Association that there are certain aspects of the AMA based schedule which allow ratings of symptoms which perhaps before were not individually considered.

In a couple of papers within the seminar materials, a rather prominent medical examiner in orthopedics, Mark Mandel, M.D., observed that, for the most part, carpal tunnel surgeries were generally successful and most people would have a very low (if any at all) impairment rating following such surgery. He also suggested that Chapter 13 of the AMA Guides (relating to subjective complaints) was probably appropriate with respect to most people complaining of ongoing, chronic pain. He suggested that, in reality, the frequency of a person ending up with a true pain syndrome following an upper extremity surgery (such as RSD or causalgia) was very low, ranging from ½% to 2%, depending upon the condition.

We think applicants' attorneys are going to attempt to push the envelope on this however, especially with respect to claimed sleep disorders and pain-based aggravations of what would otherwise be considered an underlying, non-industrial condition.

We are just beginning to see these cases. By the time of the next convention, we suspect they will be fairly commonplace, at least in connection with disabilities which would have been fairly significant under the prior schedule, but which now, independently considered, are the subject of rather low impairment ratings under the AMA Schedule. Workers' Compensation Judges, as a rule, tend to be sympathetic to the injured worker, and cases such as *Gallo/Dykes* reinforce the stated policy in the workers' compensation laws are to be liberally construed so as to ensure that an employee receives the maximum compensation available. Based on this, we see workers' compensation judges (and perhaps the courts as a whole) as being receptive to these ideas. Quite frankly, we are not sure how medical discovery is going to work given these circumstances, since the Panel Qualified Medical Examiner process appears far too cumbersome to efficiently deal with it. What we do know, however, is that things are going to become increasingly complex in the future.

If you have any questions or feel that any seminars or presentations with respect to the present state of the law or any other subject with respect to workers' compensation would be desirable or helpful, please advise and any of us will try to help.

Until the next time.

Very truly yours,

BENTHALE, NICHOLAS & McKIBBIN

By: MICHAEL K. McKIBBIN
Attorney at Law

MKM/kel