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

SAN FRANCISCO, CALIFORNIA

LOS ANGELES	SANTA ANA	SACRAMENTO	OAKLAND
900 Wilshire Blvd., #805	540 N. Golden Circle Dr. #305	2255 Watt Avenue, #165	405 14th Street, #800
Los Angeles, CA 90017-4701	Santa Ana, CA 92705-3914	Sacramento, CA 95825-0508	Oakland, CA 94612-2704
(213) 427-7820	(714) 972-8563	(916) 564-8977	(510) 452-0636

2007 SUMMER CONVENTION OF THE
CALIFORNIA APPLICANT ATTORNEY'S ASSOCIATION
SAN FRANCISCO, CALIFORNIA
JUNE 21, 2007- JUNE 24, 2007

TO OUR CLIENTS:

As has become our practice, we attended the Summer, 2007 CAAA Convention in San Francisco, California and are preparing this brief report to you for the purpose of summarizing some of the more significant issues and events which occurred during the course of the convention.

Interestingly, at least several of the contributors to the written materials have acknowledged serious flaws with the pre-Senate Bill 899 system, with one unidentified treating physician characterizing that system as a "gravy train for doctors", and an editorial (curiously, the writer was un-identified) which suggested that the writer had been commissioned to prepare a piece condemning SB 899, but found he couldn't do it, expressing the heresy (at least in this group) "that SB 899 did a lot of good, that it addressed some seriously flawed issues with the Comp. System."

For a number of years before, and in the time following the adoption of SB 899, applicant's attorneys as a cohesive group (acknowledging, of course, that there were some misgivings even among a few of the more prominent members) relentlessly pressed for more and more by way of benefits (culminating with AB 749), stridently defended the wildly increased benefits and associated costs which came with that legislation, and just as fervently condemned SB 899 as nothing more than an attempt by employers and carriers to crush injured workers. Quite frankly, for what we think is the first time, we are actually seeing some acknowledgments in the written materials (albeit brief, pretty much un-attributed acknowledgments) that things had gone quite wrong with the old system, and required fixing.

Our same, un-attributed editorial author suggests (quite rightly, we think) that workers' compensation has always been a "cyclical industry", suggesting that "every 7-10 years the industry convulses through profitability shake down and rate increases, and every 7-10 years we have a wave of reform." He suggests (a valid point we think, and a number of members we privately spoke with tend to privately agree), that the problem with the system, and reforms, is that the pendulum tends to swing to extremes, which provides the groundswell for a violent push in the opposite direction. Already, there is certainly perception, not only in the applicant's community, but also by some prominent members in the insurance industry as well that workers, especially the ones with genuinely devastating injuries, have taken a terrible hit (primarily in the area of permanent disability, and perhaps to a lesser extent with some of the medical treatment and temporary disability restrictions).

The difficulty, of course, is trying to find some middle ground. Listening to some of the individuals at the legislative session (Assembly woman Carol Midgen, for one) suggests that at least some of the movers and shakers are still quite polarized (specifically, we are not quite sure what Ms. Midgen wants to do, but some of her presentation sounded like she wanted to abolish apportionment completely, and she definitely wants to impose Labor Code § 132a liability on every employer which fails or refuses to accept back an industrially injured worker). The legislative panelists suggested Governor Schwarzenegger indicates he is going to do something administratively with respect to permanent disability benefits, and Assemblyman Joe Coto indicated he is pushing a bill which would increase the temporary disability window to five years, and the maximum number of aggregate weeks up to 156. There seems to be some consensus that if something isn't done within 90 days, nothing is going to get done.

Our unnamed editorialist suggests that what is required is incremental compromises on permanent disability indemnity, medical treatment reimbursement, and a return to a closed rating

system, and suggests that a failure to compromise at this time "will result in a complete devastation of the progress made with SB 899." What the Administrations seem to forget (Wilson, Davis, and Schwarzenegger were no exceptions) is that an Administration is only a temporary thing: eventually, there is going to be a new Administration with new ideas, and pendulums are going to start swinging again. The farther out the pendulum is, the more likely it is that something radical is going to happen (witness SB 899). Attempting to soften the sharper edges of the last reform might result in a less violent attempt to push in the other direction, although we suppose there are always those who feel that anything less than everything is unsatisfactory.

Quite frankly, although some of the harsher effects of SB 899's effect on temporary disability and medical treatment (particularly in the areas of post-surgical temporary disability outside of the current limited window, and post-surgical physical therapy) can probably be reasonably addressed, we are not sure what can be done with respect to permanent disability, without completely scrapping the current rating system and rates, and starting all over again. As will be seen in one of the later sections (and as we have all seen as a practical matter), claims are rapidly being expanded beyond the primary injury to compensable consequence impairments, some of which can result in huge ratings.

All that being said, let's take a look at the nuts and bolts:

I.

APPORTIONMENT

One of the more prominent members of CAAA said some years ago at one of these conventions that, realistically, there was no such thing as apportionment: you could always get a doctor to concede that apportionment opinions were speculative. Some of this, of course, was bravado, but at this convention even he acknowledged that his previous remark was now inoperative, and conceded that apportionment is a reality.

Without a doubt, the most significant workers' compensation decision this year was the Supreme Court's opinion in Brodie, etc., et al v. WCAB, 72, C.C.C. 565 (2007), five consolidated cases in which the court decided the proper method of calculating apportionment. The Court decided that, despite the elimination of former Labor Code § 4750, the so-called Fuentes method of calculating apportionment remained correct (i.e., deduct the percentage of prior disability from applicant's overall disability, and applicant's industrial disability is that which remains). The Court felt this was the simplest of the competing theories with respect to apportionment (fairness may have required different apportionment calculation rules depending upon the source of the pre-existing disability) and that this was to be preferred over more complex methods. The Court also noted that the purpose of SB 899 was to avert a crisis in skyrocketing workers' compensation costs and accepting that this was the intent of the legislature, the Court saw little sense in applying an apportionment formula which would have the effect of significantly increasing permanent disability payments (which certainly would have been the result had the Dykes formula been followed). The Court also (we think) significantly limited the reach of Labor Code § 3202 (the liberal construction statute), indicating that its use was limited to resolving statutory ambiguity where it was not possible through other means to discern the legislature's intent. The court also acknowledged that it was the legislature's intent to significantly alter the law of apportionment, and tie it into the declared purpose to reduce costs, and, since the legislature made no mention of the method by which apportionment was determined, obviously they had no intention of changing it.

So, applicant's attorneys are pretty much grappling with apportionment as it exists today. The first word on expanded apportionment as set forth in Labor Code § § 4663 and 4664 was Escobedo v. Marshalls, 70 C.C.C. 604, which established the following standards for apportionment:

(1) apportionment is based upon causation of permanent disability, not causation of injury; (2) applicant

has the burden of establishing the percentage of permanent disability directly caused by the industrial injury, while defendant has the burden of establishing apportionment; and (3) medical reports addressing apportionment must qualify as substantial evidence (based on relevant fact, predicated on medical probability, based on clearly stated reasoning that is not conclusory, and describing in detail the exact nature of the disability which is apportioned). The Court of Appeal decision in E&L Yeager Construction v. WCAB (Gatten), 145 Cal. App. 4th 922 (2006) was actually more of a practical application of what it is that Escobedo requires of an evaluating doctor, the court holding that a reasoned medical opinion, based on medical experience and diagnostic evidence, can support an opinion on apportionment, even when the doctor is only able to give an estimate. The important thing is that the medical examiner needs to explain the "how and why" applicant's underlying pathology (or pre-existing condition) resulted in disability (for example, see the panel decisions in Wood v. Coker Ellsworth, Inc., 2005 Cal. Wrk. Comp. PD Lexis 52 (2005); Rosales v. Your Problem Solved, Inc., case number GRO 0030087 (2006).

The respective burdens of the parties were somewhat fine tuned in Copping v. WCAB, 71 C.C.C 1229 (2006), which considered the application of Labor Code § 4664, in particular reconciling the apparent internal conflict in subsection (b) (the conclusive presumption of prior permanent disability with respect to a prior award, which was said to be a "presumption affecting the burden of proof"). Copping held that the presumption that disability reflected in a prior award was, indeed, conclusive; the rebuttable portion related to whether or not that disability actually overlapped applicant's present disability, and in this regard the employer had the burden of proving that the prior disability actually "overlapped" applicant's present disability (we are not quite sure what this has to do with a rebuttable presumption, since that language would suggest it was actually applicant's burden to prove that prior disability did not overlap the present disability, but the court's decision is what it is).

In connection with apportionment by prior award as permitted by Labor Code § 4664, Pasquotto v. Hayward Lumber, 71 C.C.C. 223 (2006), held that a Compromise and Release was not an "award" as defined in the section, although the question of whether or not a Compromise and Release could be used in that manner if a percentage of disability was set forth in the document is somewhat unclear. Similar is USFI v. WCAB (Urzua), 72 C.C.C. 869 (2007), where applicant had a prior case settled by Compromise and Release, and the Qualified Medical Evaluator stated that apportionment should be applied based upon applicant's "prior award". Since there was not an award, and defendant had not proved overlap, there was no apportionment.

There is certainly a serious issue with respect to how Labor Code § 4664 would be applied in cases involving rating under the new permanent disability schedule, where there are prior awards under the old permanent disability schedule. The panelists suggest this is like comparing apples to oranges, and they seem to have a fairly legitimate point. Disability under the old permanent disability schedule was based upon decreased ability to compete in the labor market, while the new permanent disability schedule is based upon diminished earning capacity, utilizing as its base bodily or functional impairment as those terms are used in the AMA Guides. At least at this time, the results for similar injuries and/or disabilities can be radically different (a prior award based on the old schedule may actually exceed total disability, before apportionment, found under the new schedule). Quite frankly, we are not sure that Labor Code § 4664 can be used in those circumstances (other than for a general proposition that the disability represented by that award is conclusively presumed to exist), and that the actual calculation of that disability for apportionment purposes is probably going to have to be done pursuant to Labor Code § 4663. Several panelists are suggesting that, in order to have a valid apportionment, the underlying, non-industrial condition must also result in an impairment under the AMA guides, although Escobedo and Gatten certainly suggest that this will not be required, and that

asymptomatic pathology can certainly be used in appropriate circumstances.

This could be interesting in the case of safety officers, an issue considered in Ehret v. State of California, 35 C.W.C.R. 96 (panel decision, 2007), where a California Highway Patrol officer attempted to avoid the effect of a prior award in connection with a heart condition by reference to Labor Code § 3212.3, which provided that, in connection with police officers, industrial heart trouble or pneumonia was not apportionable to prior disease. The Board held that the non-attribution clause did not apply where there was a prior award in the face of the plain language of Labor Code § 4664.

Utilizing Labor Code § 4663 to attempt to implement disability set forth in a prior award (which we think is probably going to happen when disabilities from the two schedules are considered) creates its own set of problems. The panelists suggest that the "conclusive presumption" of continued disability will no longer exist if Labor Code § 4663 is used, as it is their belief that physical rehabilitation is a permissible argument under Labor Code § 4663. Another problem relates to the body regions. In Ehret, it is clear that a prior award with respect to a heart disability clearly overlaps a present disability with respect to heart disability. However, under the new permanent disability schedule a prior award with respect to spinal disability might not necessarily overlap a present disability with respect to spinal disability, since the new Schedule divides the spine into three separate regions. Thus, if applicant had a prior low back injury and disability, it is entirely possible there would be no apportionment at all to a new schedule injury/disability with respect to the cervical spine, since that is a completely different body region (and there would thus be no overlap).

Applicant's attorneys recognize cases such as Escobedo and Gatten involve specific injuries, with apportionment to degenerative conditions which were ongoing for a long period of time prior to the industrial injury. The panelists' assertion is that there could be contribution to this degeneration (at least in part) by applicant's ongoing work activities, so it is more than likely that we will be seeing

the filing of many more cumulative trauma cases in conjunction with specific injury claims (and, especially in cases where there are significant degenerative changes, and the work involved is physically repetitive, there may actually be something there).

In a panel decision, Minns v. Mission Linen Supply, case number RDG 123435, the Board panel defined a cumulative trauma injury as resulting "from repetitive physically traumatic injuries extending over a period of time." While acknowledging that legal liability was limited by Labor Code § 5500.5 to the employers and/or carriers on the risk during the last year of injurious exposure, the panel noted that the employee is entitled to recover for any disability caused during the entire period of cumulative trauma (realistically, that period could extend over an applicant's entire employment history).
It was noted that Labor Code § 5500.5 (a) precludes apportionment of permanent disability to any prior, uncompensated period of cumulative trauma.

In Yellow Transportation v. WCAB (Huls), 71 C.C.C 473, the Board rejected an attempt to apportion ongoing degenerative disease where the doctor failed to address why the heavy labor applicant had performed over the years did not contribute to the degenerative condition. This may be a valid consideration, although in this case it appears to have been misplaced, since it does not appear that a cumulative trauma was actually at issue in terms of the industrial injury claim. An opposite conclusion appear to have been reached by Anderson v. WCAB, 71 C.C.C 1359 (2007), which is significant because the court allowed a portion of applicant's disability to be apportioned to activities of daily living.

Escobedo also did not address the question of whether apportionment was permissible when an otherwise asymptomatic condition was actually "lit up" by an industrial injury. In Sherman v. Los Angeles Unified School District, 2005 Cal. Wrk. Comp. PD Lexis 37 (2005), a Board panel held that Labor Code § 4663 did not destroy the principle that compensable injury and disability may result from

the lighting up of an underlying disease, and in this case, even though the Agreed Medical Examiner was of the opinion that applicant's trauma did not cause her rheumatoid arthritis, it lit it up, allowing it to emerge and be diagnosed, so it was correct to find that the rheumatoid arthritis was proximately caused by the employment trauma without apportionment.

The panelists seem to be conceding at this point that certain types of pathology are going to be considered legitimate subjects of apportionment. Thus, it appears that the focus is going to be whether the pre-existing condition is genuinely pathology, or simply a "risk factor". At least at this time, there seems to be a pretty good general consensus that age and gender are actually risk factors, which are not in and of themselves, appropriate subjects for apportionment. To a certain extent, the law that existed prior to SB 899 probably still has some validity, in that the employer continues to take the employee as he finds him, Duthie v. WCAB, 86 Cal. App. 3d 721, and that the use of statistical devices which are not unique to the applicant being examined are probably not going to meet with favor. In the unpublished opinion of Sierra Bible Church v. WCAB (Clink), 72 C.C.C 20 (2007), the physician used a statistical study to support his opinion that everyone over age 20 has degeneration in the spine, and used this as a basis for apportionment. Since the doctor failed to express an opinion that, separate from the statistical study, applicant would have had disability, the apportionment was deemed improper.

On the other hand, there seems to be some consensus that factors such as degenerative changes, arthritis and obesity are not actually risk factors, but are pathological conditions capable of apportionment. In Morris v. State of California, case number WCK 48519 and 48520, a panel decision, valid apportionment was found where an Agreed Medical Examiner agreed that applicant's obesity would not, in and of itself, have caused disability separate and apart from the industrial knee injury, but that 50 % of applicant's present disability was due to her obesity based on his opinion that excessive weight on a damaged joint causes additional damage.

It has been pretty much accepted that apportionment only applies with respect to permanent disability; the interim type benefits (temporary disability, medical treatment, and the like) can not be the subject of apportionment, although there has been some question with respect to whether, in cases involving multiple injuries to the same part of the body, whether an applicant can fairly Compromise and Release the case with one defendant, and then hold the remaining defendant liable for all medical expense arising from the effects of both injuries under a joint and several liability theory. Apparently, he can, at least according to County of Yuba v. WCAB (Sager), 71 C.C.C. 1598, although the sequence of when the case was actually compromised and released is somewhat unclear. Even if the overwhelming need for the medical care was created by a non-industrial event, if the industrial injury at all contributes to the need for medical treatment, the industrial carrier is on the hook (County of Stanislaus v. WCAB (Credille), 71 C.C.C. 1381 (2006), non-industrial polio, with an industrial injury apparently miniscully contributing to the need for new braces).

There have been several strange decisions where both the physician, the trial court, and perhaps even the Board has become confused with respect to what is the actual subject of apportionment. In Steinkamp v. City of Concord, case number OAK 0316754 (2006), a panel decision, the Board held that applicant's semi sedentary work limitation was totally due to his right knee replacement, despite the fact that the right knee replacement itself was made necessary by a combination of industrial and non-industrial factors. The Board held that medical treatment can not be apportioned, and since the work restriction was the result of the medical treatment, no apportionment was permissible. A similar result seems to have been reached by the panel in Hanson v. First National Bank, case number SAL 0096566, where the Board held that applicant's current disability was the result of her ankle fusion, even though this condition was again made necessary by a combination of industrial and non industrial

factors. To a certain extent, the confusion began at the level of the doctors, who insisted that the surgery caused the disability. This, of course, was compounded by the Board's clearly incorrect attempt to treat this as a medical treatment question rather than a permanent disability one (virtually every case involving surgery could be decided in the same way). Presumably, the surgery was performed to correct a problem which would have been even more disabling had the surgery not been performed. To refuse to explore causation beyond the surgery ignores the requirements of Labor Code § 4663.

In terms of what is permitted, even though an underlying award can't be attacked, a claim of new and further disability can be the subject of apportionment, Vargas v. Atascadero State Hospital, 71 C.C.C 500 (2006). When looking at prior degenerative pathology which was not necessarily symptomatic prior to the industrial injury, the most success seems to occur in cases involving relatively minor industrial injuries and resulting significant disability (Meszaros v. WCAB, 71 C.C.C. 891 (2006); Leung v. WCAB, 71 C.C.C. 437 (2006), and Madayag v. WCAB, 71 C.C.C 441 (2006), or situations where a pre-existing condition was felt to clearly make applicant more vulnerable to injury (Mello v. WCAB, 70 C.C.C 1525 (2005)). No matter what the situation is, however, the defendant has to prove apportionment. Thus, ACE USA v. WCAB (Delapen), 71 C.C.C 1469, involved a case which factually seemed similar to Gatten, but where apportionment was disallowed, with the court noting that the defendant had failed to produce a medical record substantiating the requested apportionment. While precision accuracy is not required (Marsh v. WCAB, 35 C.W.C.R. 87, an unpublished Court of Appeal decision), if a doctor is indicating that he is obtaining his opinion on apportionment "pretty much...out of thin air", Larsen v. Royal Sun Alliance, 34 C.W.C.R. 1888, that is not going to help defendant's cause either. Defendant is still required to prove apportionment by a medical record which could be considered substantial evidence.

II.

TEMPORARY DISABILITY LIMITATIONS & COLA ADJUSTMENTS

One of the products of the benefit increases which were a part of Assembly Bill 749 a number of years ago which continued to survive was the cost of living adjustment imposed with respect to various benefits. Most of the community primarily understand it to be with respect to yearly increases of the maximum temporary disability rate subsequent to January 1, 2007, but it also applies to life pensions, permanent total disability payments, and death benefits. One panelist characterized it as being the "golden lining to a dark cloud", indicating it could cause the value of a 100 % case to increase by 100 % every 12-15 years.

The relevant statutes are as follows:

1. Temporary disability. Labor Code § 4453 (a) (10). "Commencing on January 1, 2007, and each January 1 thereafter, the limits specified in this paragraph shall be increased by an amount equal to the percentage increase in the state average weekly wage as compared to the prior year."
2. Life pension/permanent total disability. Labor Code § 4659 (c). "For injuries occurring on or after January 1, 2003, an employee who becomes entitled to receive a life pension or total permanent disability indemnity... shall have that payment increased annually commencing on January 1, 2004, and each January 1, thereafter, by an amount equal to the percentage increase in the state average weekly wage as compared to the prior year."
3. Death benefits. Labor Code § 4702 (b). "A death benefit in all cases shall be paid in installments in the same manner and amounts as temporary total disability indemnity would have been made to the employee, unless the Appeals

Board otherwise orders. However, no payment shall be made at a weekly rate of less than $224.00."

COLA increases first became effective with respect to life pensions and permanent total disability, and they specifically apply only to injuries occurring after January 1, 2003 (the COLA adjustments with respect to death benefits and temporary disability apply to all dates of injury). In connection with life pensions and permanent total disability, these payments are also the first to receive adjustments, with the adjustments beginning as of January 1, 2004. There are several issues relating to calculation, and as far as we know, no case law really addressing these issues. The issues actually relate to life pensions (as opposed to permanent total disability which essentially commences as of applicant's maximum medical improvement date), since life pensions may not be paid for long periods of time after an applicant becomes permanent and stationary (about 17 years in a 99 % case). The issue relates to when the statute actually requires the COLA to be calculated in connection with the life pension, i.e., does the calculation start as of the date that payment of the life pension commences (which we would certainly argue), or must the COLA be applied to the potential life pension as of the January 1st following applicant's MMI date (which means the life pension could be more than double in size by the time payment of it actually commences). The statute is not clear on this point, but we think since all of the statutes relating to the COLA are referencing application of the adjustment following the commencement of payment, that is probably what is meant with respect to the life pension.

Another issue with respect to the life pension relates to the 15 % benefit increase required by Labor Code § 4658 (d) (2) if an employer does not offer an injured employee a return to work within 60 days of the applicant becoming permanent and stationary. We have all assumed that that 15 % increase relates only to the actual permanent disability payment, but the statute does not really say that, instead that, "...each <u>disability payment</u> remaining to be paid to the injured employee from the date of

the end of the 60 day period shall be...increased by 15 %."

We assume the term "disability payment" actually means permanent disability, since that is the subject which is being covered by Labor Code § 4658. A number of panelists contend, however, that this increase also applies to the life pension, based on the argument that the life pension is, in effect, a modified permanent disability payment. Again, we would argue this is not the case, since life pensions are not mentioned in Labor Code § 4658, but are instead the subject of a completely different section, Labor Code § 4659 (a).

The panelists indicate that the most recent measurement possible (the years 2005-2006) yield an actual increase of 4.96 %, but we think that the Department of Industrial Relations will be inclined to utilize the recommendation of the Disability Evaluation Unit. The Disability Evaluation Unit has based its recommended increase upon a 50 year average, which results in a 4.7 % increase per year. We do not believe that any carrier is going to get into trouble utilizing the DEU recommendation.

In connection with death benefits, it is noted that the statute does not specifically address the so-called COLA, instead simply providing that they are to be paid in the same manner and amounts as temporary disability. In effect, Labor Code § 4702 (b) incorporates the COLA provisions of Labor Code § 4453 (a) (10). As a practical matter, unless there are minor children involved, the increases should not affect a defendant's overall monetary liability in connection with the monetary limits set in Labor Code § 4702 (a). Where it will make a difference (and perhaps a very substantial one) is with respect to the payment of death benefits to dependent children as set forth in Labor Code § 4703.5, since the actual monetary limits in Labor Code § 4702 do not apply, and payments are required "until the youngest child attains age 18, or until the death of a child physically or mentally incapacitated from earning...". In the case of a maximum wage earner, if the minor child is young enough, application of the COLA could increase the overall monetary liability by over $300,000.00 (obviously, substantially more in the event of a mentally incapacitated child).

In connection with both death benefits and temporary disability, there is an ambiguity with respect to the benefits which are actually entitled to the COLA increase. Labor Code § 4453 (a) (10) specifies the minimum and maximum statutory wages for calculating temporary disability up to and after January 1, 2006, with what we think the pertinent sentence being: "for injuries occurring on or after January 6, 2006, average weekly earnings shall be taken at not less than $189.00, nor more than $1,260.00, or 1.5 times the state average weekly wage, whichever is greater. Commencing on January 1, 2007, and each January 1 thereafter, the limits specified in this paragraph shall be increased by an amount equal to the percentage increase in the state average weekly wage as compared to the prior year." (Emphasis added).

The issue (which even has the panelists divided) is whether the COLA increases apply only to the minimum and maximum rates or whether they apply to all rates in between. The statute seems to imply that the COLA increase would apply only to the minimum and maximum rates (otherwise, why did that statute reference the word "limits", rather than using the term "rates" or "wages"). This could, of course, result in a very unbalanced situation, with the disability rate being paid to a minimum earner within several years exceeding the rate paid to one whose wages justify a rate slightly above minimum. We suspect that this is a situation which is going to result in litigation, probably fairly quickly. At least at the Board level, we think that the question will be resolved in favor of applying the COLA to all rates, on the basis of equity. The Court of Appeal may be a little less charitable, since the specific language of the statute certainly suggests the adjustment is to be applied only to the minimum and maximum limits.

As a practical matter, at least given the present constraints on temporary disability imposed by Labor Code § 4656 (c) in connection with injuries occurring after April 19, 2004, the COLA adjustment may not have much of an affect where those benefits are timely and promptly paid (see more on this below). Although there was some contention that an applicant's temporary disability rate must be

adjusted pursuant to Labor Code § 4453 (a) (10) every year, we do not think the statute requires that; it simply provides an alternative rate for determining an applicant's statutory maximum weekly wage. We think periodic adjustment of ongoing temporary disability is still governed by Labor Code § 4661.5, which requires adjustment of temporary disability upward two years or more from date of injury. We therefore think that temporary disability is paid at the rate determined by applicant's wage at either the time of injury or disability (whichever is more) until a point two years from date of injury, at which time COLA comes into play.

Litigation at the lower level is becoming increasingly frequent with respect to the temporary disability cap imposed by Labor Code § 4656 (c) (1), which states "aggregate disability payments for a single injury occurring on or after the effective date of this subdivision, causing temporary disability shall not extend for more than 104 compensable weeks within a period of two years from the date of commencement of temporary disability payment." Subsection (c) (2) provides for an increase to 240 compensable weeks within a period of 5 years from date of injury for certain specified types of injuries (acute and chronic Hepatitis B and C; amputations; severe burns; HIV; high velocity eye injuries and chemical burns to the eye; pulmonary fibrosis; and chronic lung disease).

So far, there is not of lot of appellate guidance, but a number of trial court and panel decisions appear to be softening the effect of what at first glance appears to be pretty unconditional language, and in their zeal to allow continuing temporary disability in situations which they otherwise feel to be unfair, some judges appear to be simply misreading the statute. The current fights appear to be in four areas:

1. Estoppel. This issue arises in connection with an argument that defendant has delayed medical treatment, thus causing the prolongation of temporary disability. The issue is presently on reconsideration, but the most serious case on this issue appears to be one entitled Maria Murillo v. High Point/Norco Ranch, case number LAO 848876, in which

Judge Ward found a 113 day unreasonable delay in authorizing a back surgery, and held that the 104 week period was extended by this amount of time as the result of the unreasonable delay. A second case, Kathy Casazza v. Petaluma School District, case numbers SRO 132058 and 135138 suggest estoppel applies where medical treatment is delayed because of utilization review de-certification, and the pursuit of the second opinion remedy, which the court characterized as being "entirely the doings of the defendants". We do not believe that a party's action in legitimately pursuing statutory rights (such as timely use of utilization review, or timely invoking medical-legal type objections) can be characterized as inequitable (and some amount of inequity and wrong doing is required to invoke estoppel).

We would expect to see panel decisions with respect to these cases relatively quickly (both of them went up on reconsideration a couple of months ago).

2. Commencement of payment. As it turns out, the language of section 4656 (c)(1) is not that clear after all. A number of trial court decisions have attempted to discern just what constitutes defendant's first payment of temporary disability, and how this affects defendant's obligations under the statute. Almost uniformly, the trial court decisions have held that a reimbursement of state disability benefits, or a payment of retroactive benefits, does not establish the "commencement" date as being the date for which benefits were first paid Casasazza v. Petaluma School District, case number SRO 132058 and 135138 (November 2, 2006); Corona v. KPMG, case number SJO 259203 (February 14, 2007) (allowing defendants to claim the commencement date as occurring on the first date of the state disability payments, which were subsequently reimbursed, would impermissibly require applicant to finance her own workers' compensation coverage based on her contributions to state disability); Adame v. Automotive

Engineered Products, case number SDO 0328208 (April 19, 2007); Howard v. Mercer Staffing, SAC 340252 (February 5, 2007); and Farley v. Albertson's, case number LBO 369136 (April 20, 2007).

All of these decisions have held that "the date of commencement of temporary disability payment" refers to the date on which the defendant first issues a check, which is probably a reasonable interpretation, although arguments can still be made on both sides until definitive appellate authority appears (and that would appear to be coming soon). It is this date from which the two year period referenced in the statute is measured, but there is another component to the section, that being the reference to "104 compensable weeks", which, while somewhat coextensive with the two year limitation, we think is intended to mean something entirely different. Thus, we think the trial court got it wrong in Howard v. Mercer Staffing, supra, which essentially views the language as meaning essentially the same thing as two years from the date of commencement of payment (the Judge notes there is only two days of difference between 104 compensable weeks and 2 years, but we don't think the legislature would have had to use both terms, if they were meant to mean the same thing).

We think the trial court which came closest to getting it right was Adame v. Automotive Engineer, supra. Judge Harwayne suggested that a defendant's retroactive temporary disability payment could be included in the aggregate limitation (104 weeks), although the time period for payment of temporary disability allowed by the statute (2 years) commenced as of the date the defendant issued its first check. In other words, a defendant would have exposure for payment of temporary disability at any time extending 2 years from the date of its first actual payment of temporary disability, but in no event would defendants's overall liability exceed 104 compensable weeks (in Adame, the judge found that, as of the date of the hearing, including payment of retroactive benefits and reimbursement of the Employment Development Department, the defendant had paid applicant 102.14 weeks of temporary disability, and thus had an obligation for an additional 1.86 weeks).

2. Multiple injuries. Labor Code § 4456 (c)(1) is actually pretty clear on this, referencing temporary disability payments for a "single injury". Trial decisions (for example, Casazza v. Petaluma School District, supra) have indicated the statute means exactly what it says, and that additional injuries potentially multiply the periods and temporary disability payable by the number of injuries. Thus, it is likely that claims for admitted specific injuries will be accompanied by claims for cumulative trauma injuries, to potentially double the amount of temporary disability. This creates some additional problems for defendants. Where a cumulative trauma and admitted specific injury claim are concurrently filed particularly where the defendant has an MPN, a strategic decision to admit the cumulative trauma is sometimes made and recommended for the purpose of maintaining medical control. A denied claim enables applicant to self-procure medical treatment, and bring in medical opinions regarding causation and disability through the back door, so to speak, by virtue of the opinions of the self-procured treater (admissible by virtue of Labor Code § 4062.3 (k), a situation which could put an applicant at a significant advantage). On the other hand, admitting the additional injury does have medical treatment consequences (it potentially doubles the statutory limit on therapy and chiropractic treatments set forth in Labor Code § 4604.5 (d)(1)), and now appears to certainly have the potential of significantly increasing potential temporary disability liability. In at least one of the cases, a trial judge found it significant that a temporary disability benefit notice referenced only one of two industrial injuries. If there is more than one admitted compensable injury it would be best if the benefit notices referenced all of them.

3. Amputations. There has been a push to include within the definition of amputation any type of surgery in which some sort of body part or piece of bone is cut out, particularly

spinal surgeries. A few cases such as Kirkpatrick v. Dominican Santa Cruz Hospital, case number SAL 107786 (January 19, 2007), accepted the proposition that where portions of the cervical disc were removed during the course of a neck surgery, that constituted an amputation, bringing an applicant within the 240 week exception of Labor Code § 4656 (c)(2). Contrary is Ortega v. R.C. Drywall, case number LAO 0852561 (December 14, 2006), wherein the trial judge accepted the more traditional definition of amputation (essentially the removal of all or a part of a limb), suggesting that to rule otherwise would pretty much include virtually any surgery within the technical definition of an amputation. The Board has granted reconsideration for the purpose of further study with respect to this issue.

In terms of what actually constitutes temporary disability, industrial leave benefits, which are defined as being temporary disability are included within the definition of temporary disability for the purpose of implementing the limitations imposed by Labor Code § 4656 (c). Salmon v. State of California Department of Transportation, 206 Cal. Wrk. Comp. PD Lexis 41 (2006).

On the other hand, Labor Code § 4850 payments (payable to certain safety officers) are defined as salary continuation, and are intended to be distinct from temporary disability indemnity, so the period during which an injured employee receives these payments is not counted against the temporary disability cap.

Finally, with respect to temporary disability, we have the rather strange case of Sarabi v. WCAB, 72 C.C.C. 778 (2007), which the panelists cite for the proposition that if a timely Petition to Re-Open is filed within five years of date of injury, a defendant has exposure for temporary disability even if that period of temporary disability arises more than five years from date of injury, a result apparently contrary to the principles set forth in Fekkers v. WCAB, 67 C.C.C. 92 (2002, writ denied), and Berry v. WCAB, 69 C.C.C. 1320 (2004, writ denied). Sarabe is said to overrule Fekkers and

Berry, but we don't think so, since this case has some rather unique facts. In Sarabe, applicant was medically found to be in need of surgery within five years of the date of injury, and was found to be temporarily disabled at that time, but there was apparently some delay in providing this medical treatment. Subsequently, applicant developed a non-industrial medical condition which required treamtent and a deferral of the surgery, so the treating doctor apparently indicated that applicant's industrial condition was permanent and stationary until he was able to undergo the surgery. Once applicant had completed his treatment with respect to the non-industrial condition (now in excess of five years from date of injury), he underwent the surgery, and the court held that defendant was responsible for temporary disability in connection with the surgery. To an extent, this almost sounds like an estoppel case, but the important point is that there was medical opinion finding applicant to be temporarily disabled and in need of surgery (which eventually took place), prior to the expiration of the five years. We think the situation would have been much different had applicant not had any medical evidence of temporary disability, or for example, had actually been working at the end of the five year period.

At least in connection with injuries occurring after April 19, 2004, this may not be so much of a problem anymore.

III.

MEDICAL LEGAL PROCEDURES

The medical legal procedure has become rather complex, especially in represented cases. One problem, of course, is the fact that the only regulations actually in place at this time relate to the assigning of Qualified Medical Examiner panels for unrepresented workers. Panels with respect to represented cases are requested in the same manner as in unrepresented cases, but the Medical Unit has been very loose in connection the time frames (if an unrepresented worker does not receive his panel within 15 days of the request, technically he can choose any Qualified Medical Examiner he wants

pursuant to Labor Code § 139.2 (h)(1), although there is no corresponding section in represented cases). We have heard there is a trial court decision out of San Francisco (presently on reconsideration),wherein the trial judge felt, in the absence of regulations, an analogy to unrepresented cases was proper, and the parties were allowed to choose their own Qualified Medical Examiner where the Medical Unit had not (in the trial judge's mind) timely assigned a panel. We understand that, in represented cases, panels are being issued about 45 days after request.

There are a number of proposed regulations relating to the issuance of panels in represented cases, which are now undergoing further modification, and will apparently be posted again. More than likely, there will be some changes, but the regulations in large part, are simply modifications of the regulations relating to unrepresented workers. It does appear, however, that the initial requestor for a panel will be in a position to control the medical specialty of the panel, and it is the panelists' opinion that the initial requestor will be the person who actually starts the medical legal process (the person first offering the use of an Agreed Medical Examiner). While that may be true in injury AOE/COE cases where the evaluation is being conducted pursuant to Labor Code § 4060, we think a little more is required with respect to cases arising under Labor Code § § 4061 and 4062. In those case (involving admitted injuries) objections to the opinion/recommendation of the treating physician is required. Labor Code § 4062 is very specific with respect to the timing of objections (within 20 days of the receipt of the report), and, while Labor Code § 4061 does not contain a specific limitation, the courts will apparently look to the reasonableness to the time in which the objection is made. The bottom line, however, is that an objection does need to be made before the medical legal procedures authorized by these sections can be invoked. The panelists suggest that the offer to use an Agreed Medical Examiner be set forth in the initial representation letter, but we don't think that is going to be sufficient to justify the issuance of a panel unless the representation letter meets the objection requirements of Labor Code § 4061 or 4062.

There seems to be an idea by the panelists that new Qualified Medical Examiner panels can be requested in connection with medical disputes involving different specialties in the same case. Although we have seen some exceptions, that generally has not been the practice of the Medical Unit, which seems to take the position that only one panel per case is issued. Theoretically, if evaluations in different specialties are required, the panel QME is supposed to make the referrals and obtain the consultations.

The new regulations were supposed to be in place by now; the word is that the revised regulations will be posted for additional comment in the coming months, and will hopefully be adopted before the end of the year. We will see.

What is clear, however, is that the Board is not willing to accept medical reporting other than that which is specifically authorized by statute. In Ward v. City of Desert Hot Springs, 71 C.C.C. 1313 (2006), a case involving a post January 1, 2005 injury, defendant attempted to obtain a comprehensive medical legal evaluation pursuant to Labor Code § 4064 (d), which provides "...no party is prohibited from obtaining any medical evaluation or consultation at the party's own expense....all comprehensive medical evaluations obtained by any party shall be admissible in any proceeding before the Appeal Board (except as provided in certain sub divisions of Labor Code § 4061 and 4062)". It is clear that this subsection was probably overlooked in connection with the adoption of SB 899, since several of the sub sections referenced no longer exist, but the ones which do exist (§ 4061 (d) and § 4062 (b) specifically reference evaluation of permanent disability and the procedures for obtaining a second opinion regarding spinal surgery). In any event, the Board held that the more recent sections (4060, 4061, and 4062) basically state that medical evaluations shall be obtained only by the procedures specified therein, so the apparently inconsistent language of Labor Code § 4064 (d) is of no help, and any report obtained pursuant to that sub section is inadmissible.

In Ehret v. State of California, 35 C.W.C.R. 96 (2007), the Board reached the same result,

throwing out a Labor Code § 4064 (d) report obtained by the applicant.

IV.

MEDICAL TREATMENT

One of the primary focuses in connection with the enforcement of medical treatment relates to that which is the subject of a prior award, since these procedures present the possibility of supplemental attorney fee awards. The primary statutes being referenced are Labor Code § 4607 (award of attorney fees in resisting a Petition to Terminate an Award of Medical Benefits); Labor Code § 5813, in conjunction with Regulation 10561 (relating to attorneys fees and costs incurred as the result of bad faith actions or tactics); and Labor Code § 5814.5 (award of attorneys fees when payment of compensation has been unreasonably delayed or refused subsequent to the issuance of an award).

The panelists concede there are few situations where application of Labor Code § 5813 would be applicable. The most promise (at least until recently) was Labor Code § 4607, in connection with which several Board decisions had held that, where there was a medical award, a denial of medical care is the equivalent of a Petition to Terminate, which entitled applicant to attorney fees, a proposition which was recently affirmed in decisions by the District Court of Appeal in Smith v. WCAB and Amar v. WCAB. However, the California Supreme Court has now granted review in both Smith and Amar, thus throwing the ability to collect post-award fees for enforcing medical care under Labor Code § 4067 into doubt. Smith and Amar actually liberalized the concept quite a bit, suggesting that the mere initiation of a contest with respect to medical care, even if it was resolved informally, would give rise to a legitimate claim for attorney's fees.

We would have thought Labor Code § 5814.5 would present the best opportunity for a post-award attorney's fee in connection with the enforcement of a medical care award, and it might, but the present state of the law probably encourages the judge to consider the imposition of a penalty in conjunction with the attorney's fee. In Bergeron v. Transportation Unlimited, case number SJO 225717

(2007), a panel decision, applicant claimed an unreasonable delay in providing post-award medical treatment, and filed a Petition for Attorney's Fees pursuant to Labor Code § 5814.5 (a penalty was not requested). The trial judge awarded the attorney's fees (based upon a finding of unreasonable delay), which defendant for some reason appealed, apparently claiming, perhaps among other things, that Labor Code § 5814.5 attorney fees could not be awarded in the absence of a penalty. Sure enough, the Board held this is what the statute says, so reconsideration was granted, and the matter was remanded back to the trial judge for "further proceedings...consistent with this opinion." We imagine the further proceedings will result in the imposition of a penalty to satisfy the requirements of the statute.

Won the battle; probably lost the war.

This may become critically important in connection with the newly adopted administrative penalty regulations (Regulation § 10225 et seq.), which became effective as of January 1, 2007. The regulations require workers' compensation judges to report penalties based upon conduct occurring after April 19, 2004 to the Administrative Director, and two or more such penalties are deemed to suggest conduct in the "course of business", and trigger and automatic audit.

If the audit determines that the carrier or administrator knowingly violates Labor Code § 5814 (the unreasonable delay statute) with a frequency that indicates a general business practice, administrative penalties can range as high as $400,000.00.

Additionally, utilization review regulations (8 C.C.R. §§ 9792.2-9792.23) became effective as of May 4, 2007, imposing another set of draconian administrative penalties based upon violations of the rules relating to utilization review. The range of penalties is as high as $400,000.00 for repeat violations, with the significant penalties relating to de-certifying an authorization request where the requested treatment is not within the reviewer's scope of practice ($25,000.00); failure to comply with the requirement that only a licensed physician (in most cases) participate in connection with the de-certification of medical treatment ($25,000.00); failure to discuss/document attempts to discuss

reasonable options for a care plan with the requesting physician in cases of concurrent review ($10,000.00; Regulation 10225 (h) defines "concurrent medical treatment" as being that treatment which is being rendered during an inpatient hospital stay); failure to establish a utilization review plan ($50,000.00); failure to employ or designate a physician as medical director ($50,000.00). The most draconian penalties are set forth in Regulations 9792.12 and 9792.13.

What concerns us is the frequency of utilization reviews we see which do not identify either the physician conducting the review (at times, the review is attributed to only a nurse), or fails to identify the specialty of the physician where the physician is identified. We think these may be running afoul of the regulations. We note that, in terms of some of the de-certification penalties, Rule 9792.6 (s) provides that utilization review does not include determinations of work relatedness of injury or disease (in other words, causation). We suspect that those issues need to be determined by reference to medical treatment objections pursuant to Labor Code § 4062 (at least where the primary injury is admitted).

It does appear, however, that MPNs may be becoming an accepted way of life (where they exist) as vehicles for providing medical care. Although Knight v. UPS, 71 C.C.C. 1423 (2006) held that a failure to provide the required notices with respect to an employee's rights under an MPN was the legal equivalent of a neglect or refusal to provide medical treatment, thus entitling the employee to self-procure treatment, it turns out this presents only a temporary setback. Assuming that occurs, defendant is still not foreclosed from transferring applicant's care into the MPN pursuant to the transfer of care provisions of Regulation 9767.9. This might involve a bit of delay in connection with ongoing treatment or chronic conditions (as set forth in the section), but an eventual transfer is mandatory.

In Babbitt v. OW Jing dba National Market, 72 C.C.C. 830 (2007) (*en banc*), the Board held that an employer may transfer an injured worker's care to an MPN physician where they comply with all the statutory requirements in connection with any date of injury, including those on which an award

has already been issued. In connection with transfers of care and application of the "serious chronic condition" exception, which allows applicant's present physician to treat up to a year, judges see this exception as essentially requiring a "weaning" period, and tailor the length of time required to the length of time the self-procured and/or free choice physician has actually been providing care. In other words, if an applicant is notified within several weeks of free choicing a non-MPN physician that care must be transferred to the MPN, most judges who have considered this issue with us have expressed the opinion that the "weaning period" required substantially less than a year.

We know, however, that medical care could still be chaotic, even if the applicant is within the MPN. Rodriguez v. Select Personnel Services, case number POM 290281 (panel decision 2007) decided that if an injured worker disagreed with the opinion of an initial MPN physician who reported him permanent and stationary and able to return to work, the injured worker was not required to invoke Labor Code § 4061 or 4062, but instead was entitled to select a second MPN physician pursuant to Labor Code § 4616.3 for the purpose of providing additional medical treatment (presumably, the injured worker could go through another such a choice as well).

Lastly, on the subject of medical treatment, employers should be cautioned (again) not to treat their industrially injured workers differently than their other employees. In Anderson v. WCAB, 72 C.C.C. 389 (2007), an employer (for reasons which are not really clear) required applicant to use his vacation time for medical appointments related to his industrial injury (non-industrially injured employees were entitled to use sick leave for medical appointments). There did not seem to be any rational reason for this distinction, so the employer was found to have violated Labor Code § 132 (a).

V.

USE OF THE NEW PERMANENT DISABILITY SCHEDULE

At the time we did our last booklet following the 2007 Winter Convention, the *en banc* decisions of Pendergrass/Baglione I had just issued (basically applying the old permanent disability

schedule where temporary disability was paid and/or any Qualified Medical Evaluation was obtained prior to January 1, 2005), and we confidently predicted that the Court of Appeal would not review the issue, since it was a transitory one which would disappear in a few years. We were wrong. Since then, the composition of the commissioners on the Workers' Compensation Appeals Board changed, the decisions in Pendergrass/Baglione I were vacated, and were replaced by two new *en banc* decisions, Pendergrass v. Duggan Plumbing, 72 C.C.C. 456 (2007) and Baglione v. Hertz Car Sales, 72 C.C.C. 444 (2007). Actually, we thought there might have been some merit to the rationale of the old Pendergrass decision (the initial payment of temporary disability triggers the obligation to send the notice pursuant to Labor Code § 4061, and if the obligation is created prior to January 1, 2005, then the old schedule would apply pursuant to the exceptions set forth in Labor Code § 4660 (d)). Baglione, on the other hand, made no sense, and it was our feeling the Board had engaged in grammatical gymnastics to reach its tortured interpretation of that subsection that any comprehensive medical legal report obtained prior to January 1, 2005, whether or not it found an indication of permanent disability, was sufficient to trigger application of the old schedule.

Quite frankly, we did not think either case really looked at the big picture, which we thought essentially required application of the new schedule for all injuries except in those cases where an applicant was determined to be permanent and stationary, or had at least returned to work, prior to January 1, 2005.

That is probably the essential effect of the re-issued opinions in Pendergrass and Baglione. Pendergrass held that the true triggering date in Labor Code § 4660 (d) is the date on which defendant is actually required to send the Labor Code § 4061 notice (rather than the date on which the obligation is created), while the re-issued Baglione decision concedes the plain language of sub division (d), finding there is no reason to treat a comprehensive medical evaluation report any differently than the report of a treating physician in connection with the indication of the existence of permanent disability.

Where we were completely wrong is how far this issue would go, and we now have Costco Wholesale Corporation v. WCAB, 72 C.C.C. 582 (2007), wherein the Court of Appeal has embraced the re-issued holdings in both Pendergrass and Baglione. All these cases rely on the proposition that SB 899 required its provisions to go into effect as quickly as possible because of the perceived workers' compensation crisis, and on the further language in Labor Code § 4660 (d) to the effect that the new schedule was to promote consistency, uniformity, and objectivity. It was felt the legislature clearly intended the new schedule to apply in as many cases as possible.

Apparently, we are not done. The Costco Wholesale case is not yet final, and may be further appealed, and we understand there are several decisions currently pending in the Court of Appeal with respect to the same issue. One case before the Third District Court of Appeal apparently involves the old Aldi issue, that issue being whether or not all pre January 1, 2005 injuries should be evaluated using the old schedule.

What has the Association's hierarchy positively giddy is another trial court decision out of the San Francisco Board (the birthplace of Aldi), Scott Boughner v. CompUSA, case number SFO 491230 (May 9, 2007), wherein the trial judge found that the future earning capacity adjustment in the new permanent disability schedule was arbitrary, capricious, not based on any evidence at all, and invalid. She distinguished Costa v. Hardy Diagnostic, 71 C.C.C. 1797 (2006) (*en banc*), which found the new permanent disability schedule to be valid, essentially on the ground that she admitted into evidence the deposition of Robert Reville, Ph.D., a co-author of the Rand Report, a document which the commissioners in Costa had rejected. This seems to circumvent the requirement that *en banc* decisions are binding on trial judges, but reconsideration has been requested, and the matter is on appeal.

What that means for us, however, is that applicant's attorneys are being urged to challenge the new permanent disability schedule in every case set for trial, to designate all the documentary evidence

that was designated in Boughner, and to designate an expert for the purpose of testifying with respect to earning capacity. As a practical matter, we don't know that this issue is going to be seriously contested in low value cases, but the situation could prove to be a nuisance in the higher dollar ones.

Much of the talk with respect to AMA schedule is still with an eye to circumventing the schedule by use of expert testimony on the issue of earning capacity (although even Boughner did not offer any insight with respect to how a case would be rated if the FEC adjustment were thrown out). In Wehrenberg v. Liberty Mutual Insurance Company, 45 C.W.C.R. 56 (2006), the panel suggested that the appropriate time in which to present such expert witness testimony would be at the time of the cross-examination of the Disability Evaluation Specialist. Although a party is not allowed to present expert opinion bearing on the disability factors described in the rating, the panel held that a worker is entitled to present vocational rehabilitation testimony to the effect that the worker is precluded from working in the open labor market. We had some concern in connection with the Costco opinion based upon the suggestion of applicant's attorneys that it required reimbursement of an applicant's costs with respect to expert witnesses on earnings on every case, but in Wixom v. City of Concord, case numbers SFO 0410896, WCK 0056416 (2007), the panel held that a vocational rehabilitation expert's input is not necessarily a reasonable cost under all circumstances, particularly if it has no real relevance to the issues being tried, and that it must be determined whether a particular cost being requested is reasonable under the circumstances of a particular case, and if so, what the reasonable value of the cost is.

In connection with the actual use of the AMA guides, the panelists reminded attendees to pay attention to compensable consequence type conditions (the impairments with respect to which are often greater than the impairments allowed in orthopedic cases, which form the vast majority of workers' compensation claims), which could be used to bolster the value of the claim. Particularly in connection with back cases, it was suggested that there is undue reliance upon the DRE and range of motion categories, and that more attention should be paid to the so-called Cortico spinal track injuries, as they

rate significant higher. It was noted that symptom description in the higher category of DRE are similar to the types of symptoms described for Cortico spinal injuries.

VI.

OTHER ISSUES

Undocumented workers cause particular and unique problems. Del Taco v. WCAB (Gutierrez), 65 C.C.C 342 (2000) held that an undocumented worker who is provided with modified work following an industrial injury but was terminated once his undocumented status was discovered, was entitled to temporary disability, but once he became permanent and stationary, was not entitled to vocational rehabilitation (since the employer had permanent modified work available), since that would put him in a better position than other, similarly situated workers who were in the country legally.

An interesting approach was taken in Farmer Brothers Coffee v. WCAB (Ruiz), 133 Cal. App. 4th 533 (2005), where defendant argued that an undocumented worker was not entitled to any workers' compensation benefits at all, on the ground that California's workers' compensation law was federally preempted by the Immigration Reform and Control Act of 1986, which made it unlawful to hire or continue to employ an undocumented alien. The employer contented that applicant had fraudulently obtained his employment by means of a fake Social Security card. The court held that it was the employment, and not the industrial injury, which was obtained by the use of fraud, and that while the IRCA prohibited employment, there was nothing in the language of the statute which expressly impacted the requirements of the state workers' compensation law, so benefits were payable.

That being said, the question then becomes the amount. These problems are probably more prevalent in cases where the employer is aware of his worker's immigration status, with the panelists complaining that in many cases wages and hours are "off the books". The panelists indicate that methods of ascertaining proper wages include not only the applicant's own testimony, but subpoenaing co-workers, vocational experts experienced in dealing with undocumented workers and the manner in

which they receive earnings, as well as the employer himself (and forcing the employer to answer, under oath, exactly what was paid). The panelist don't seem to have much concern for the argument that there could be adverse tax consequences to this type of prove up, arguing that the employer faces adverse consequences as well for not reporting the income and making appropriate contributions.

There were also discussions with respect to what to do in those cases where undocumented workers are threatened with deportation in connection with their pursuit of a work injury. The panelists contend that threatening a deportation against an applicant in connection with his pursuit of a workers' compensation claim is probably the legal equivalent of extortion, and a crime under Penal Code § 518 and § 519. Where a lawyer does it during the course of defending a case, that lawyer probably runs into the same problem as he would face in connection with threatening a criminal fraud action against an applicant in an attempt to induce that applicant not to pursue a case further: it is a violation of Rule 5-100 of the State Bar rules regarding ethical conduct (prohibiting the threatening of criminal, administrative, or disciplinary charges for the purpose of gaining a civil advantage).

The bottom line is, don't make such threats as a part of the bargaining process. They really have no place there. If a fraud referral is warranted, just make the SIU referral without making it a part of the civil proceeding (unless, of course, applicant is convicted, at which time that conviction would then play a role in connection with applicant's entitlement to benefits).

The same thing is true in connection with deportation. Quite frankly, initiating deportation proceedings actually appears to be somewhat far removed from the issues which would normally be encountered in a workers' compensation proceeding (as opposed to insurance fraud, for example). However, if one feels under an obligation to take an active role in enforcing immigration laws, then that person should simply take the action he or she believes is required , again, however, without reference to the issues being negotiated or litigated in the workers' compensation case.

On the subject of earnings is County of San Joaquin v. WCAB (Davis), 72 C.C.C. 187 (2006),

and the only reason we can determine that the Court of Appeal actually took this case was for the purpose of making a public policy declaration that there would be absolutely no discrimination against jurors in connection with determining their disability rates should they be injured while acting as a juror. In this case, a SCIF attorney reported for jury duty, where he was paid $5.00 a day (as opposed to his attorney's salary, which was easily maximum), and was injured while acting as a juror. Defendant the County calculated his wages based upon his juror's stipend of $5.00 per day, which, of course, was unreasonable on its face, and the only thing more amazing than this is that the County took it as far up the appellate level that they did (the County lost at every level). Many people attempt to avoid jury service as it is; there would be mass avoidance, if it was realized that compensation benefits would be based upon the juror's stipend rather than a person's usual wage.

Heiman v. WCAB (Aguillera), 72 C.C.C. 314 (2007) stands for the proposition that, in agency type relationships, liability for workers' compensation benefits can extend to unexpected places. In this case, there are essentially three levels: home owners, which are in turn represented by homeowner's associations, which in turn hired a property management company to manage its affairs. The property manager hired an unlicenced and uninsured contractor (the work required a contractor's license), and the contractor's employee was electrocuted during the course of the work.

The target employer was the management company, which argued that it could not be the employer since the applicant did not work the required number of hours to qualify under the household employee restrictions of Labor Code § § 3351 (d) and 3352 (h). The Court found those sections did not apply since the property manager was not a homeowner. The same was true as far as the homeowner's association was concerned, so the homeowner's association was liable as well. The individual home-owners, however, were exempted from liability pursuant to these sections, although the homeowner's association's argument that the home owners are being found indirectly liable because of the liability being imposed on the association certainly has some merit (especially if the homeowner's association

has no insurance for this, and must pass its costs on to the individual home owners). We would think, however, that the homeowners's association would be second in line, and the property manager would still be primarily liable (since it was the one that did the hiring).

Finally, Arciga v. WCAB, 72 C.C.C. 1 (2007) seems to stand for the pretty much elemental proposition that the post-termination defense requires that the employer has no pre-termination knowledge of applicant's injury. In this case, applicant complained to a foreman that her hands were hurting, and the foreman provided her with tape. The Court also noted that this was a cumulative trauma injury, which requires the existence of disability, and the disability did not arise until applicant's physician determined that her condition was work related, which followed her termination.

VII.

CONCLUSION

Upcoming events include the possible issuance of regulations relating to medical legal procedure in represented cases, and possible legislation modifying the temporary disability limit and cap, as well as with respect to a modification/increase in permanent disability benefits (although no one is really saying what proposed form these increases are supposed to be taking).

If the legislative panelists are perceiving things correctly, they have suggested Governor Schwarzenegger has now agreed to take a look at modifying permanent disability, although there is still some suggestion that it is his preference that this be done administratively, rather than legislatively.

There is still lots of litigation going on with respect to the new permanent disability schedule and the temporary disability limits, and significant decisions in connection with post award attorneys fees are expected as well.

Life in workers' compensation seems to be more complex, and we think things will continue to become more complex. Applicant's attorneys as a group are certainly complaining that business is down, but there still seems to be a significant number who are willing to attempt to work within the

present system.

If you have any questions regarding this booklet, or would like us to conduct presentations or seminars with respect to it, or any other issue, we would be more than happy to oblige.

Until the next time,

Very truly yours,

BENTHALE & McKIBBIN

By: MICHAEL K. McKIBBIN
Attorney at Law

MKM/kda

2007 WINTER CONVENTION OF THE CALIFORNIA APPLICANT ATTORNEY'S ASSOCIATION SAN DIEGO, CALIFORNIA JANUARY 25, 2007-JANUARY 28, 2007

TO OUR CLIENTS:

We attended the Winter 2007 CAAA Convention in San Diego and, as has become our custom following our attendance at this event, we are preparing this brief report attempting to summarize some of the more significant issues and events identified over the course of the convention affecting the direction of the workers' compensation industry as a whole, and our clients in particular, tempered, of course, by our own cynical observations.

Interestingly, the histrionics of the past few years are pretty much gone (one participant referred to the attitude as being one of "resignation"), except possibly with respect to the legislative session, which is primarily an occasion for political grandstanding, in connection with calls for reform of the system.

There are not nearly the number of political movers and shakers showing up at this event as occurred a number of years ago. The primary speaker was State Senator Carole Migden, who promises legislation reforming the system by the end of the year. Exactly what this legislation would do was expressed in rather vague generalities, although the focuses are apparently going to be health care delivery and an employee's right to return to work after a period of industrial disability (funny how everyone now insists upon returning to work; when rehabilitation was an available benefit, it appeared no one was able to return to work). There is also some suggestion that reform of the permanent disability schedule would be a subject of this bill, as well as restrictions upon apportionment.

Exactly how this will sit with the Governor is unclear; he has apparently expressed a

preference that reforms of the current workers' compensation system be addressed by way of Administrative Regulation rather than Statute.

That is the problem with workers' compensation legislation, however. No one seems to see what is specifically being proposed until it suddenly comes up for a vote (that seems to have been true with the various applicant's Bills which were circulated after Gray Davis became governor, as well as SB 899). Perhaps we will see something more concrete and specific at the next convention.

In the meantime, despite some continued bleating about the unfairness of it all, the primary focus of this convention appeared to address the issue of how to make money working within the new system. As one panelist responded to an audience question respecting the possibility of a legal challenge to the medical-legal procedures currently mandated by SB 899, "if you want to do it, best of luck, but I don't have the time". This seems to reflect a growing attitude that continued broadside attacks at SB 899 may now be falling into the category of Don Quixote attacking windmills, and it is now time to get on with the business of making a living.

Interestingly, the convention was conducted in such a manner as to leave one with the impression that this is going to be very possible.

With all this in mind, let's take a look at some of the categories of immediate concern.

I.

MEDICAL CARE

The basic rule is set forth in Labor Code § 4600 (a), which provides:

> *"Medical....treatment... that is reasonably required to cure or relieve the injured worker from the effects of his or her injury shall be provided by the employer. In the case of his or her neglect or refusal reasonably to do so, the employer is liable for the reasonable expense by or on behalf of the employee in providing treatment".*

Such a simple concept, with such complex consequences. One of the most complex areas

is in the area of what the Association refers to as "augmented benefits", and can include the following:

1. Weight loss programs and clinics. Braewood Convalescent v. WCAB, 48 C.C.C 566 (1982); Taylor vs. State of California Department of Rehabilitation, Cal Wrk. Comp. PD LEXIS 49 (2005).
2. Gym memberships, Taylor vs. State of California Department of Rehabilitation, supra.
3. Non-industrial medical treatment claimed to be necessary to facilitate industrial treatment. Department of Corrections v. WCAB (Rowan), 62 C.C.C. 35 (1997) (hip replacement, since, without it, applicant could not walk, which was necessary for his industrial heart condition); SafeCo Insurance Company v. WCAB (Potts), 62 C.C.C. 382 (1997) (coronary bypass surgery, although there was some suggestion that the coronary bypass surgery may have been made necessary by a failure to authorize earlier, industrial treatment).
4. Hot tubs and jacuzzi's. County of Tehema v. WCAB 54 C.C.C. 213 (1989); City of Manteca v. WCAB (Shaefer), 67 C.C.C. 1342 (2002), (a classic example of why the California workers' compensation system is in disrepute, since the applicant owned and managed 12 health care facilities in the area, all of which contained whirlpool equipment).
5. Specialty Vans. Fredy Springs Union School District v. WCAB (Laughlin), 68 C.C.C. 279 (2003); Webb School v. WCAB (Roberts), 62 C.C.C. 1329 (1997); Long v. WCAB, 63 C.C.C. 370 (1998). (This basically falls into the same category as residential modifications, such as the enlargement of doors and the providing of lifts).
6. Nurse care managers. Lamin v. City of Los Angeles, 69 C.C.C. 102 (2004).

7. Home health care. Martinez v. WCAB, 64 C.C.C 1176 (1999); Henson v. WCAB, 27 Cal. App. 3rd 452 (1972); U.S. Steele Corporation v. IAC (Hutchinson) 30 C.C.C 159 (1965); Bass v. WCAB (City of Lynwood), 66 C.C.C. 1178 (2001); Evergreen Health Care v. WCAB, (Gruendig), 70 C.C.C. 1610 (2005); Los Angeles Times v. WCAB (Herbinger), 70 C.C.C. 504 (2005).

8. Housekeeping. Smyers v. WCAB, 49 C.C.C. 454 (1994).

Certain types of augmented benefits can be rather easily understood: durable orthopedic equipment, Doctor's Medical Center of Modesto v. WCAB (Bonar), 70 C.C.C., 1637 (2005) (this involved a mattress, which somewhat pushes the envelope, but the same principle would apply to devices such as wheelchairs, crutches, braces, and the like); plastic surgery, Cano v. WCAB, 65 C.C.C., 625 (2000) (almost a no-brainer following a serious burn injury); and assisted living, Joseph Mike v. WCAB, 68 C.C.C. 266 (2003) (although more expensive, it is certainly subject to far less abuse than home care).

As the Association correctly points out, medical treatment is not apportionable. County of Stanislaus v. WCAB (Credille), 34 C.W.C.R 296 (2006) (applicant's disability was 1 % industrial, with the remaining 99 % due to pre-existing polio, but the carrier was on the hook for medical treatment). This, of course, provides for attorney fee opportunities.

Obviously, augmented medical treatment which is demanded, the subject of contest, and is then obtained, either through settlement or Order of the Board, following an initial award of medical treatment (either interim or final), would probably now be subject to the attorney fee provisions of Labor Code § 4607 (which allows an applicant attorney fees where a defendant initiates a proceeding to terminate an award of medical care).

In the cases Smith and Amar v. WCAB, 72 C.C.C. _____ (2007), the Court of Appeal gave judicial support to the concept of a constructive petition to terminate medical benefits, indicating it

saw no difference between formally filing a Petition to Terminate Benefits, and informally denying medical treatment, referencing, with approval, several panel decisions, County of Sonoma v. WCAB (Callahan), 62 C.C.C. 973 (1997) (writ denied); and United Airlines v. WCAB (Dickerson), 64 C.C.C. 1511 (1999) (writ denied). The message we are hearing is that, in every case where there is a post Award disputed issue of medical care, defendants are going to be seeing Petitions for Attorney's Fees, even if the issue was eventually informally settled (that was the case in Smith).

In the absence of awards, attorney's fees may be a little harder to come by, although the housekeeping and home health care claims (sometimes, it is difficult to differentiate between the two, although home health care is considered a true medical benefit, while housekeeping is a little farther removed, and is examined on a case by case basis) present pre-Award opportunities for extra fees, and can be terrible traps for defendants. Many of the cases in which claims for these benefits arose occurred after the services had already been rendered by family members, and thus were more in the nature of lien proceedings wherein large amounts of compensation were sought for services rendered in the past, and the lump sums obtained to resolve these claims are, of course, subject to attorney's fees. We suspect we may be seeing these issues explored a little more often.

In order to justify these augmented benefits, however, it does appears to be recognized (at least to some extent) that the treating physician's prescriptions for these treatment modalities must be specific with respect to what is required, and why. In other words, a prescription script all by itself is more than likely going to be insufficient to create any obligation on the defendants; the recommendation for the augmented treatment modality is going to have to be supported by substantial evidence.

It is also important to understand, however, what is not considered an augmented treatment benefit. In Clerkin v. WCAB (City of Long Beach), 68 C.C.C. 1201, an applicant's treating psychiatrist suggested applicant's psychiatric condition would improve greatly if the materials he

needed for his start up business were purchased for him. Some sanity prevailed, and the judge held that the recommended items were associated with vocational rehabilitation and not medical treatment, and defendant was not obligated to provide them (at least as items of medical treatment). The same principle applied to educational items, Mar v. WCAB (Safeway), 63 C.C.C. 771 (1998), where applicant was given a prescription for completing his education.

Utilization review tends to play an ever pervasive role, and will almost certainly play a role in connection with augmented benefits. The Association members insist that the ACOEM Guidelines not only do not apply after 90 days from date of injury have passed (the idea is that the ACOEM Guidelines apply only to acute medical conditions, not chronic ones), and have some authority for this proposition, Hamilton v. SCIF, 32 C.W.C.R. 249 (2004); LA Times v. WCAB (Herbinger), 70 C.C.C. 504 (2005), but they also argue that the ACOEM Guidelines do not address most or all of these augmented benefits in any event. That does not preclude Utilization Review, but it is only the ACOEM Guidelines which are given a statutory presumption of correctness (which we think seems to be observed more in breach by the Workers' Compensation Appeals Board than anything else). It is also claimed that the ACOEM Guidelines don't recognize treatment modalities which simply temporarily "relieve", as opposed to providing a long term benefit. There is law to the effect, however, that treatment that merely "relieves", as opposed to "cures" is reasonable and necessary, County of Tehema v. WCAB, 54 C.C.C. 513 (1989), and more recently, Grom v. Shasta Wood, 69 C.C.C., 1567 (2004).

These are somewhat dangerous decisions if they remain unqualified, in that they provide justification for ongoing, repetitive, and seemingly never ending conservative treatment, which has resulted in astronomical liens. The most prominent abuses, of course, have been physical therapy and chiropractic, although these modalities (as well as occupational therapy), are now subject to the "statutory" utilization review set forth in Labor Code § 4604.5 (d)(1), restricting these modalities

to 24 each per injury. Of course, the recommendation by the Association panelists is to plead a lot of injuries, but this type of attitude misses the point: most solid, credible medical opinion is to the effect that, if something concrete has not been accomplished within 3-4 months of this type of treatment, it's time to try something else. The response, of course, is going to be that the chiropractic sessions provide about 3 or 4 hours of relief, so that should entitle applicant to an infinite number.

The statutory basis of Utilization Review is set forth in Labor Code § 4610, and it is essentially a system for the regulation of medical treatment recommendations to ensure reasonableness and necessity. Regulation 9792.10 (b)(1) does prohibit the discontinuation of care pursuant to a Utilization Review until the requesting physician has been notified of the decision and a care plan has been agreed upon which is appropriate for the injured worker's medical needs.

Timeliness in utilizing Utilization Review is critical. If Utilization Review timelines are missed, then not only is Utilization Review invalid, but the report generated by Utilization Review is inadmissible for any purpose at all, including review by an evaluating physician. State Compensation Insurance Fund v. WCAB (Sandhagen) and Sandhagen v. WCAB, 71 C.C.C. 1541 (2006) (it is hard to believe that all of the effort in connection with these two appeals was over an MRI). Utilization Review is one of those rare instances where reports of non-examining physicians are allowed into evidence, Willette v. AU Electric Corporation 69 C.C.C. 1298 (2004), (another instance would be the report of the Independent Medical Examiner appointed in spinal surgery cases).

A defendant actually has options with respect to challenging medical treatment. Brasher v. Nation Wide Studio Fund, 71 C.C.C. 1282 (2006) suggested that a defendant can challenge a medical decision by utilizing Utilization Review, or can bypass Utilization Review and simply challenge the decision by way of an objection under Labor Code § 4062 (this case arose in the

context of a spinal surgery). It is noted that this 2 level objection was sanctioned by Sandhagen, but we also understand that a Petition for Review is presently pending in the Supreme Court with respect to Sandhagen. Where Utilization Review is used to challenge treatment recommendation, the burden then seems to fall on the employee to object to that determination pursuant to Labor Code § 4062 (Willete, supra).

Applicant's attorneys complained that this process, as well as the Sandhagen and Brasher approach of giving a defendant the option of objecting to medical treatment in two different manners, obstructs the goal of expeditious medical treatment. They suggest requesting Expedited Hearings seeking interim awards of medical treatment pending resolution of the treatment issue, although one has to wonder what issues would be left to resolve if the treatment in dispute is awarded as the part of an Interim Award. We certainly think that defendants would have a reasonably solid argument for objecting to that treatment in cases where the defendants' positions are supported by timely Utilization Reviews. A defendant might have a much more difficult time prevailing in a situation where there was no medical evidence supporting its position (i.e., Utilization Review), and the defendant was relying solely upon a Labor Code § 4062 objection (perhaps, even with respect to spinal surgery).

It should be noted that, where an Agreed Medical Examiner is used, the Agreed Medical Examiner's opinion with respect to treatment controls, and "trumps" Utilization Review. Aguilar v.WCAB, 70 C.C.C. 885 (2005); Regents of the University of California v. WCAB (Rewald), 70 C.C.C. 897 (2005). This is based upon the principle that the Board observes a strong policy in favor of deferring to the expertise of physicians jointly chosen by the parties. Green v. WCAB, 70 C.C.C. 294 (2005).

With respect to Medical Provider Networks, although there is still quite a bit of distrust, they are not quite the hated institutions they were when they were first being implemented. This is

because most applicant's attorney's will acknowledge that most of the networks include most of the applicant's doctors with whom we are well familiar (we had one of our clients lament that using the First Health MPN was almost like business as usual, since it included virtually everybody).

The Administrative Director, Ms. Carrie Nevans, on one of the panels, indicated that the idea behind Medical Provider Networks was that the carriers would carefully choose credible and reputable doctors in whom they had confidence. While that has happened in a few limited situations, a number of the networks were created independent of the carriers, which then subscribed to them. Ms Nevans pointed out that, in Texas, formal Utilization Review is only permitted with respect to non-network physicians. Unfortunately, that probably would not work here.

Like Utilization Review, effective use of an MPN depends upon timeliness, i.e., timely notice to the applicant of the existence of an MPN, and how to choose a doctor from it. Failure to do this probably enables the applicant to free choice a doctor. Knight v. United Parcel Service, 71 C.C.C. 1423 (2006). There is some argument being made that the applicant's ability to free choice a consulting physician at defendant's expense in a serious case pursuant to Labor Code § 4601 (a) enables the applicant to choose a physician outside of the Medical Provider Network. Where an MPN exists, we really do not see the statute authorizing this; while applicant may certainly choose a second opinion physician, we think he probably has to do it within the network.

Some applicant's attorneys actually suggest they may be better off with denied cases, since they are then not constrained with the MPN's in terms of obtaining medical treatment. As we have previously observed, this actually can put a defendant in a very difficult position, since the reports of treating physicians are always admissible, and in a denied case the defendant's only option is the use of either an Agreed Medical Examiner, or a panel Qualified Medical Examiner, pursuant to Labor Code § 4060 and § 4062.2. There is some suggestion by applicant's attorneys that the Administrative Director has only 15 days to respond to a panel request and, if there is no response,

the requesting party can then select a QME of their own choosing. This is based on an analogy to what is permitted in the case of an unrepresented employee, but there is no similar statute or rule with respect to represented employees. We do know that, despite its language that either party may obtain reports at their own expense, there is now a panel decision ruling Labor Code § 4064 cannot be used to circumvent the medical-legal process set forth in Labor Code § § 4060 through 4062.2. Ward v. City of Desert Hot Springs, 71 C.C.C. 1313 (2006). Whether section 4064 would be appropriate where the Medical Unit is found to have failed in its duties to assign a panel is unclear.

We do know there have been reports of the Medical Unit refusing to issue panels pursuant to Labor Code § 4060, where the case has already been denied (apparently taking the position that the only purpose of a panel is to determine compensability, and where the case has been denied, there is no longer any need to determine compensability). This would appear to be contrary to both the explicit terms and intent of the statute, but, then again, the question is whether Labor Code § 4064 would find application in such a case.

II.

Settlements, Including Medi-Care Involvement

There was a time when many of the panelists at these conventions suggested that Compromises and Releases were not in their client's best interests for various reasons, and that the resolution of choice should be an Award. That thinking seems to be changing, although we think there is going to be a new focus on the value of medical treatment for the purpose of inflating the value of these types of settlements. Certainly, however, the panel that concerned itself with settlements (and Medi-Care) was focusing on the type of case which, if not necessarily involving astronomical permanent disability, did involve what was likely to be significant medical care.

Medi-Care is becoming an increasingly frequent topic at these conventions, and a number of years ago, when the topic was first specifically discussed, it had the effect of terrifying the

practitioners on both sides into believing that Medi-Care would be suing everyone concerned in a settlement which it did not believe adequately protected its interests. The result was the establishment of a cottage industry which basically evaluates an applicant's medical needs for the purpose of calculating a Medi-Care allocation.

The attitude toward Medi-Care at this convention actually began showing signs of resentment, with applicant's attorneys complaining of long delays in obtaining Medi-Care Set Aside approvals, and one of the leading attorneys in a firm the principle practice of which is processing Medi-Care Set Asides, characterized Medi-Care's attitude as being, essentially, that they need to issue a "permit" (in his words, "may I have a permit to settle my case, Sir?"). He notes that the only specific right of action which is given Medi-Care in the regulations is the right to be reimbursed for Medi-Care expenditures for industrial medical treatment rendered prior to resolution of the case (or where there is an Award for such care in place). 42 U.S.C. § 1395 y. It is pretty much agreed that the statute is completely silent as to what duties exist once a workers' compensation case is settled, although, if the injured worker has received funds for future medical expenses as a part of the settlement, then Medi-Care is not obligated to pay the work related medical bills.

The statute does not require a settlement permit; it is only required that the parties consider Medi-Care's interests in reaching a settlement. There are various "safe harbors", but the circumstances under which Medi-Care must be considered are essentially four:

1. Applicant has applied for or is receiving Social Security:
2. Applicant is 62 ½ years old or older:
3. Any settlement for $250,000.00 or more, where it is anticipated that applicant will receive Medi-Care within the next 30 months;
4. Any settlement for $25,000.00 or more, where applicant is actually receiving Medi-Care. A suggested solution here, where applicant has pled multiple

injuries, is to settle each injury for less than $25,000.00 (this is not truly a safe harbor: Medi-Care has simply made a policy decision that it will not deal with settlements this small).

The real problem arises where Medi-Care perceives a "shifting" of what would normally be considered a compensation burden on to Medi-Care. In such a situation, Medi-Care can elect to not recognize the settlement, and is potentially empowered to take a credit against applicant's Medi-Care benefits in the amount of the settlement. However, there is nothing in the statutes which specifically requires that Medi-Care either approve an allocation, or anything else, before a settlement can be effective.

That being said, the Medi-Care allocation is certainly a good idea for the purpose of protecting applicant's interests, and providing a comfort level to the defendant. Applicant's attorneys are beginning to get the idea, however, that the Life Care Plan can be a dangerous implement, since Medi-Care will take those documents and rely upon them for the purpose of establishing an allocation. The undersigned had a case where the Life Care planner went literally nuts and came back with a plan projecting a cost of 10 million dollars. We thought much of this was "fluff", but now the idea was on paper, the mind of applicant and his spouse (who were already envisioning lottery-like proportions) were clearly set in concrete, and you just can't settle a case like that. We definitely agree with at least some of the applicant's attorneys: Life Care Plans are to be avoided if at all possible.

On the other hand, commissioning a Medi-Care allocation study is the more conservative approach, and certainly puts all parties in a position to legitimately claim that Medi-Care's interests were taken into consideration (whether or not a Medi-Care approval was obtained).

The panelists did point out that, where any type of Medi-Care allocation has been made in a settlement, whether approved or not, there does not appear to be any record of enforcement by

Medi-Care against the parties to that settlement anywhere in the country.

Even assuming the size of a Medi-Care allocation appears unmanageable on its face, the allocation can be managed by structuring it (much in the same way as a Structured Settlement). This can have the effect of reducing the actual outlay for the Medi-Care Set Aside by as much as 50 %.

Medi-Care does not discount medical expenses by present day value; they insist that the allocation reflect dollar for dollar the cost of Medi-Care qualified expenses over the projected life of the applicant. Applicant's attorneys actually take a more difficult view of medical expense: they insist that, since the cost of medical care continues to rise, not only is a present day value discount inappropriate, but the amount of present day expense calculated should actually be increased to account for cost increases. This, of course, could break a settlement as well. We suspect we are probably going to see a harder line with respect to the value of medical care because of what are perceived to be lower permanent disability ratings.

There does seem to be some general consensus that one method of making these large settlements somewhat more palatable, is by structuring them. Studies show that most applicants tend to be out of money in a few years after a large, lump sum settlement, so this ensures that there will be a source of money for years to come to accommodate an applicant's needs. In fact, a number of applicant's attorneys favorably discussed the concept of actually structuring the attorney's fee portion of the settlement (rather than the traditional method of taking them all up front).

The panelists pointed out several problems which they feel need to be avoided in Compromises and Releases. First, several of the panelists warned against entering into stipulations in the Compromise and Release to the effect that a certain type of injury and/or disability (i.e., psychiatric injury) did not occur, especially if the applicant has undergone psychiatric evaluation and treatment. Such a stipulation certainly prejudices the lien claimants in connection with that

particular condition (which is why we like it), and might also expose applicant, his attorney, and the doctors to a fraud allegation.

Secondly, the panelists advised being careful with respect to full release language in a Compromise and Release. It is noted that the Compromise and Release in its standard form, releases only claims related to workers' compensation. Claxton v. Waters, 69 C.C.C. 895 (2004).

Finally, applicant's attorneys are taking notice of the availability of the Subsequent Injuries Benefit Trust Fund as a method of dealing with the increased apportionment which is being seen in today's cases. They are finding that, even if a large chunk of an applicant's disability is apportioned away, they can sometimes restore the entire amount of the benefit through an application with the Subsequent Injuries Benefit Trust Fund. The essential rule requires that the overall disability (industrial and non-industrial disability) be in excess of 70 %, and that the work related disability rates at least 35 % or more when considered alone and without regard to age or occupation adjustment.

III.

APPORTIONMENT

The hottest topic right now is the formula to be used in applying apportionment. Over the past year, a slew of Court of Appeal decisions have issued with respect to the subject. At least in cases where the apportionment related to a prior injury sustained while in the service of the same employer, the Court of Appeal in Nabors v. WCAB, 71 C.C.C. 704 (2006), and E&J Gallo Winery v. WCAB, (Dykes), 70 C.C.C. 144 (2005), held that the proper formula was to subtract the monetary value of the prior disability from the monetary value of applicant's present disability, and award applicant the balance. Prior to SB 899, the so-called Fuentes formula required subtraction of the percentage value of the prior disability from the percentage value of applicant's overall disability, and applicant received an award for the remaining percentage. Subsequent to the issuance of Nabors

and Dykes, seven additional decisions issued from various Courts of Appeal, one of which (Brodie v. WCAB, 71 C.C.C. 1007 (2006), involving prior Stipulated Awards with the same employer, felt that a modified Nabors/Dykes approach was appropriate, and felt that the prior disability should be valued at today's rates, and that the monetary value should then be subtracted. The other six (Welcher v. WCAB, Strong v. WCAB, Lopez v. WCAB, and Williams v. WCAB, 71 C.C.C. 1087 (2006), and Davis v. WCAB and Torres v. WCAB, 71 C.C.C. 1669 (2006)), rejected the Nabors /Dykes approach, observed that the legislative intent in enacting SB 899 was to reduce workers' compensation expenditures and that the Nabors/Dykes approach tended to contravene this purpose, and thus felt that the Fuentes subtraction approach was still the appropriate method. These cases involved a mix of circumstances, including cases where the apportionment was to non-industrial conditions (a situation which we felt was a valid and significant distinction from the situation involved in Nabors/Dykes). The Supreme Court has granted hearings in all of these cases except Davis and Torres, and in those cases (the decisions with respect to them are fairly recent), Petitions for Review have been filed, and are presently pending.

We suspect hearings will be granted in these cases as well, since they involve the same issues.

Speculating what the Supreme Court is going to do is a dangerous game. However, one has to wonder why Petitions for Review in Nabors and Dykes were rejected, while Petitions for Review in cases involving different apportionment formulas were granted. Applicant's attorneys would like to believe that this signals the Supreme Court is going to approve the Nabors/Dykes formula. We are not so sure. In the limited context in which they were issued (apportionment was to prior industrial injuries sustained while an applicant was working for the same employer), the Supreme Court might have felt the decisions were correct ones. The much more difficult question relates to cases where apportionment is clearly to a congenital, non-industrial condition (which clearly appears to be the case in Lopez v. WCAB), as well as those cases involving injuries which occurred

while an applicant was in the service of a different employer. Perhaps those circumstances all require different rules. It is our understanding that the Supreme Court has agreed to an expedited calendar for these cases.

In the meantime, the Workers' Compensation Appeals Board has issued an *en banc* decision in Erickson v. Southern California Permanente Medical Group, 71 C.C.C. ____ (2006), in which it has decided that it is appropriate for all workers' compensation judges to defer the issue with respect to how to apply apportionment until the Supreme Court has issued its decision. Judges have been directed to issue interim awards of the undisputed amount of permanent disability owed, together with attorney's fees thereon, and defer the decision with respect to apportionment until after the Supreme Court has ruled. Essentially, this means that these interim awards will apply apportionment in the most restrictive manner, i.e., the subtraction method.

Participants were warned that they should not request that judges reserve jurisdiction over the apportionment issue, since this might run afoul of the statutory prohibition of amending and/or altering awards after 5 years from date of injury. The advice is that the judges should take the matter off calendar, although, quite frankly, we can't see much of a practical difference. We suppose that the theory here is that only an interim award has been entered, rather than a final one, but we suspect some defendant with an interim "Fuentes" type decision will attempt to take the position that it is too late to apply a different type of apportionment, if that attempt comes in excess of 5 years from date of injury. Quite frankly, from an applicant's standpoint, although it might create some hardship, we think their safest course of action would be to simply defer the entire decision, and that way an applicant would not have to contend with the argument that they are trying to amend or alter a permanent disability award in excess of 5 years from date of injury.

There is a claim that E.L.Yeager Construction v. WCAB, (Gatten), 71 C.C.C., 1687 (2006) is an unpublished decision, but we're not so sure, since it appeared as a published decision the Daily

Journal (2006 DJDAR 16317) (it appears to be published by order dated 12/15/06). We think this case contains an excellent explanation of the principles originally set forth in Escobedo v. Marshall's, 70 C.C.C. 604 (2005). Escobedo involved application of the new apportionment statutes to a pre-existing, degenerative condition, and Yeager involved the same sort of facts. The doctor in Yeager explained that an MRI showed advanced and progressing degenerative changes, even though there was not much by way of symptomology, indicated his experience in dealing with these types of conditions, and gave what the Court considered to be a reasonable estimate of apportionment. The Board's decision denying apportionment was rejected, with the Court observing that, while the Board was paying lip service to the new apportionment rules, it was insisting upon prior disability of some sort to establish apportionment, and this was not what was required by statute.

Kopping v. WCAB, 71 C.C.C. 1229 (2006) involved an interpretation of the "presumption" provisions of Labor Code § 4664 (a prior award is "conclusively presumed" to continue to exist, and that the presumption is one "affecting the burden of proof", which actually suggests a rebuttable presumption. The Court struggled with this, but solved the problem by ruling that the conclusive presumption relates to the existence of the award itself, although the defendant retains the burden of showing that the disability represented by the prior award overlaps applicant's current disability (we are wondering what happened to the "rebuttable presumption affecting the burden of proof" here, which the Workers' Compensation Appeals Board felt imposed a burden upon applicant to show that there was no overlap). We think this probably requires that the medical reporting underlying the prior award be submitted, at least for the purpose of showing the factors of disability upon which the prior award was based.

This could still prove to be problematic because of the different method by which disability was measured in the past. Prior to SB 899, disability was measured by determining the diminution

of an applicant's ability to compete in the open labor market, which involved the consideration of work restrictions, while now an applicant's disability is measured by impairment under the AMA Guides, modified by his loss of future earning capacity. Applicant's attorneys are arguing that there can never really be an overlap between two radically different types of disability, and that the result is that the disability resulting from prior awards is going to have to be evaluated under Labor Code § 4663 (in connection with which the concept of medical rehabilitation still exists).

There is probably still a lot of litigation left in these sections.

IV.

RATING CASES

One of the hot topics here has been the issue of which schedule applies to pre-January 1, 2005 injuries. Aldi v. Carr, McClellan, Thompson & Horn, 71 C.C.C. 783 (2006) was an *en banc* decision where the Workers' Compensation Appeals Board found that Labor Code § 4660 (d) does require that certain pre-January 1, 2005 cases be rated pursuant to the new schedule. Since then, the Board panel decisions that we have seen appear to have done their best to emasculate the effect of Aldi, and we have found most trial judges have taken the hint, and are attempting to push the envelope as far as possible in terms of rating pre-January 1, 2005 injuries by the old schedule. Two recent panel decisions, Torres v. SDM Precision Products, and Shayesteh v. Abbott Laboratories (both recently reported in the California Workers' Compensation Reporter) were panel decisions which held, first, that the "Comprehensive Medical-Legal Report", referenced in sub-section (d) did not have to address permanent disability, and as long as such a report was made prior to January 1, 2005, the old schedule applied (we thought this twisted the language of the statute, and certainly contravened legislative intent), and, second, that the date on which the duty to send the Labor Code § 4061 notice referenced in the statute arises is the date which controls what schedule applies (thus, the initial payment of temporary disability created the duty, so if temporary disability was paid prior

to January 1, 2005, the old schedule applied).

These two decisions have now been confirmed by two *en banc* decisions, Baglione v. Hertz Care Sales, 72 C.C.C. ______ (2007), holding a comprehensive medical-legal report, whether or not it addresses permanent disability, issuing prior to January 1, 2005 results in the old schedule being applied, and Pendergrass v. Duggan Plumbing, 72 C.C.C. ____(2007), which actually expands Shayesteh somewhat. Pendergrass ruled the date on which the duty to send the Labor Code § 4061 notice arises controls, but then suggests that this duty is created on the first day the temporary disability is paid, or should have been paid (which potentially causes a pre-January 1, 2005 industrial injury to be rated under the old schedule, even if temporary disability is paid for the first time after January 1, 2005, if it can be shown that there was a period of legitimate temporary disability which should have been addressed prior to that).

It was our impression that the Court of Appeal would probably not take much interest in this issue, since it is essentially a transitory one: in a couple of years, the issue should no longer exist. However, a recent Court of Appeal decision (the Daily Journal, again, suggests the case is published, 2007 DJDAR 1045, while, again, the Association claimed this one was unpublished, although why this would be, since it appears to be a case of first impression, is completely unclear) was issued in State Compensation Insurance Fund v. WCAB (Echeverria), 72 C.C.C. _____ (2007), in which the court essentially held that the one line, conclusionary statements by treating physicians issued prior to January 1, 2005, that, based on their experience, they anticipated the applicant would have permanent disability, were, without more, unsupported by substantial evidence, and could not form the basis for applying the new schedule. The Court left open the possibility that an applicant need not be permanent and stationary for a physician to reach such a conclusion, but that the physician had to make some reference to the record as to why he expected permanent disability.

One of the most significant cases was Costa v. Hardy Diagnostic, 71 C.C.C. 1797(2006), the

much ballyhooed broadside attack on the present permanent disability schedule. Such an attack has been the subject of discussion by CAAA for quite some time, and, in this particular case, the Workers' Compensation Appeals Board pretty much considered most of the evidence which CAAA wished to introduce with respect to the adoption of the permanent disability schedule for purpose of showing that it was not evidence based, and that the assumptions upon which the future earning capacity limitations were based were arbitrary and speculative. Despite attempting to put a positive spin on the decision, the result has to have been a heart-breaking loss, as the Workers' Compensation Appeals Board upheld the schedule, and found that it presumptively established levels of permanent disability. In not too much of a departure from the previous line of cases under LeBouef, 48 C.C.C., 587, the Board did find that, in the appropriate case, applicant could introduce evidence (vocational evidence primarily) to rebut the schedule, and show that it did not accurately assess a particular applicant's loss of future earning capacity (basically, on a case by case basis). Applicant's attorneys are suggesting that the case stands for the proposition that, in every case where vocational evidence is used to attempt to rebut the schedule, Labor Code § 5811 entitles an applicant's attorney to reimbursement of costs incurred in connection with obtaining that vocational evidence, but we are not so sure. We would think that there would have to be at least a preliminary showing of a legitimate dispute, and solid reasoning why the future earning capacity adjustment set forth in the schedule should not apply. Routinely running up several thousand dollars in vocational expert costs in every case, we think, would be an abuse.

Another issue addressed in connection with ratings was how to approach pain, which under chapter 18 of the AMA Guides, takes only a 3 % add-on. In fact, the California Permanent Disability Schedule is even more restrictive than the AMA Guides, since the AMA Guides would allow the add-on with respect to each region of the body injured, while the permanent disability schedule restricts the add-on to each injury, no matter how many regions of the body were injured.

There is some question whether this was a legitimate restriction of the guides, in light of Labor Code § 4660 (b) (1), which stated that the Administrative Director "shall incorporate" the impairments set forth in the guides in connection with the schedule.

In any event, although chronic pain syndromes are recognized in the Guides, these relate to the extremities and generalized pain conditions such as fibromyalgia, are not addressed.

To a certain extent, it is said that these generalized pain conditions can be addressed by reference to other impairments (psychiatric impairments, sleep disabilities, internal medicine type difficulties, etc.), which are also conditions which applicant's attorneys advise they will be examining in connection with orthopedic disabilities (by far the majority of industrial injuries, and the type of injury which took the biggest hit in the new permanent disability schedule).

There was a nuts and bolts discussion with respect to the methods to be used for challenging ratings. When a judge issues rating instructions, and/or a recommended rating is issued, it is not always necessary to schedule the deposition of the rater (although, out of an over-abundance of caution, this is almost always done). Fidelity & Casualty Company of New York v. WCAB (Ratzel), 32 C.C.C. 271 (1967) explains that if the trial judge has improperly described the factors of permanent disability, cross-examination of the rater is not necessary. Rather, the proper procedure is a motion to strike the rating. It is only when a party objects to the manner in which the rating is calculated (the actual percentage), that a cross-examination is necessary, and Ratzel states that the party objecting to the rating is entitled to offer rebuttal evidence. In the past, when anticipating trouble with the rating specialist, we had designated private raters as potential expert witnesses, but several panel decisions a number of years ago suggested that bringing in a private rater was inappropriate. If the stakes are high enough, however, we would certainly consider listing such an expert witness, and argue admissibility under Ratzel.

V.

HEARING AND TRIAL PROCEDURES

Initiation of formal court proceedings is accomplished by the filing of an Application for Adjudication of Claim, or its legal equivalent (the initial document can be a Compromise and Release or Stipulations with Request for Award). Rule 10400 of the Rules of Practice and Procedure. This is generally accomplished at or about the time that compensability is being determined. In connection with the determination of whether to accept injury AOE/COE, the employer has 90 days from the date the Claim Form is filed in which to make that determination pursuant to Labor Code § 5402 (b). For many years, the Board took the position that if the employer knew or should have known of a potential industrial injury and/or disability, this was the constructive equivalent of the filing of a Claim Form, but the Supreme Court finally put a stop to this nonsense in Honeywell v. WCAB, 70 C.C.C. 97 (2005), holding that the statute meant exactly what it said, i.e., the 90 day period began to run when the Claim Form was filed (in the absence of an estoppel). For a number of years before this, the courts have also held that the statute did not require that the denial of injury AOE/COE take any particular form, as long as there is an actual rejection of the claim prior to the expiration of the 90 day period. Rodriguez v. WCAB, 59 C.C.C. 857 (1994). As long as there was some evidence which established that the rejection had taken place (such as the chronological notation in the claim notes), that would suffice.

On the other hand, once the 90 day period is past, in order to present evidence on the issue of compensability, the defendant is required to show that that evidence would not have been available within the first 90 days in the exercise of due diligence. State Compensation Insurance Fund v. WCAB (Welcher), 60 C.C.C. 717 (1995) (a nightmare of a case, in which there was late denial, followed by defendant obtaining a plethora of medical evidence showing applicant's condition non-industrial, although defendant was unfortunately unable to show that the medical evidence would have been unavailable within the first 90 days).

As we also like to tell our clients, it is easier to undo a denial than it is to undo an admission. In Williams v. WCAB, 64 C.C.C. 995 (1998), the employer did not question applicant's psychiatric claim, accepted liability, provided benefits, but then, close to trial, discovered evidence which supported a denial of injury. Unfortunately for the city, that evidence had always been available to it, so it was stuck with the claim. Similar to this is Memorial Hospital Association v. WCAB (Caldwell), 60 C.C.C. 779 (1995), where defendant, pretty early on in the case, conceded that its denial was late, and led applicant to believe that the case was presumptively admitted. As it turned out, the denial was not late after all, but defendant's earlier concession was held against it, and the case was deemed admitted.

As we all know, at some point following the initiation of litigation, if the case is not resolved, it is going to be set for a Mandatory Settlement Conference. It should be noted that, with respect to the requirement that a computer printout of benefits be available at the Mandatory Settlement Conference in every case where a defendant has paid benefits (Rule 10607), the provision of such a printout could actually apply in a case where injury AOE/COE is denied, since the defendant is required to pay up to $10,000.00 in medical expenses while it investigates compensability (Labor Code § 5402 (c)), and this is certainly considered a benefit.

The most significant event at the Mandatory Settlement Conference (other than setting the matter for Trial), is the closure of discovery (Labor Code § 5502 (e) (3)). The Board's solicitousness toward pro-per applicants is reflected in its Policy and Procedure Manual (Section 1.45), wherein the judges are admonished to ensure that the unrepresented applicant understands how to prepare the Pre-Trial Conference Statement, and understands its legal effect. To a certain extent, one might almost get the impression that the judge is being placed in the position as the applicant's advocate. On the other hand, if the Pro-Per gets it wrong, sometimes the court will actually treat it like an employer, as was the case in County of Sacramento v. WCAB (Estrada), 64 C.C.C. 26

(1999), where an applicant who insisted upon representing herself failed to take the necessary steps to secure competent medical reporting prior to the Mandatory Settlement Conference, and the supplemental report she later obtained was excluded.

With respect to the discovery closure, however, the most important points lay within the exceptions. The most significant case in this regard is Tyler v. WCAB, 62 C.C.C. 924 (1997), which examined Labor Code § § 5701 and 5906, and held that, despite the closure of discovery, the workers' compensation judge had authority to supplement the medical record where deemed necessary, and obtain additional evidence, even post Trial. This principle seems to be grounded in Labor Code § 5708, which, in essence, provides that WCAB hearings "shall not be bound by the common law or statutory rules of evidence and procedure, but may make inquiry in the manner... which is best calculated to ascertain the substantial rights of the parties....", etc. Thus, we see the later case of McClune v. WCAB, 63 C.C.C. 261 (1998), in which applicant got a second bite of the apple after credible medical evidence tended to show his disability to be completely non-industrial. The defendants in that case strenuously argued that supplemental evidence was permitted in Tyler because the judge specifically found that neither of the reports submitted by the examining doctors in that case to be particularly credible, while, in this case, the medical opinions truly constituted substantial evidence. Although paying lip service to the principle that the "employee bears the burden of proving his injury was...." industrial, the court noted the liberal construction policy of the Workers' Compensation Act, and stated that "....where the medical evidence is in conflict, the WCAB does not exceed its statutory powers when it grants reconsideration to direct the taking of additional evidence".

Of course, this is not the type of decision that we see favoring the defense, although there have been occasional decisions allowing post-MSC sub rosa, presumably because even the Workers' Compensation Appeals Board does not like fraud.

We do note, however, that where applicant made a tactical decision not to list evidence (because it seemed to be in conflict with respect to the date of injury), applicant's later decision to try to get the evidence in under Tyler was precluded in Telles Transport v.WCAB (Zuniga), 66 C.C.C. 1290 (2001), and, like Estrada, a slipshod disclosure of evidence at the MSC can still result in an applicant being precluded from submitting non-disclosed evidence in support of his case. San Bernardino Community Hospital v. WCAB (McKernan), 64 C.C.C. 986 (1999).

The lesson here? If you want to get it in, disclose it at the time of the Mandatory Settlement Conference. We note that we may be running into more of these battles with applicants who attempt to introduce vocational expert testimony for the purpose of rebutting the schedule. They may list witnesses, but will more than likely not list reports or documents supporting those witnesses' testimony, and we will take serious exception to that.

The judges making up the panel in connection with hearing procedures also had a number of tips, which they indicated the parties would be well advised to keep in mind. They advise (and this is primarily directed to applicants) that parties may want to consider the use of Evidence Code § 776, for the purpose of calling adverse witnesses during their portion of the case, since this gives them an opportunity to control the direction of testimony. It is also noted that, where examining a witness, Evidence Code § 768 provides that it is not necessary to show, read, or disclose to the witness any part of the writing (perhaps handy when cross-examining a witness about a prior award when the actual documents are unavailable). Particularly irksome to the judges are failures to appear, and it is noted that Regulation 10562 does give the Board power to issue some rather severe evidentiary sanctions against non-appearing parties (for example, determining an issue in their absence).

Although Expedited Hearings (actually known as Priority Calendars pursuant to Labor Code § 5502) are scheduled only with respect to admitted injuries, they can take place with respect to

denied body parts pursuant to Section 1.20 of the Policy and Procedure Manual (although, if testimony is going to be extensive, the Expedited Hearing can be converted to a Mandatory Settlement Conference).

It should also be noted that non-attorneys on both sides are required to file a Disclosure with the Board to that effect (Section 1.120 of the Policy and Procedure Manual), except in the case of a non-attorney representative representing a defendant, the client need not sign the Disclosure form.

The judges also admonished the parties to be careful with respect to Stipulations, since they are binding. That is the gist of the Weatherall cases, County of Sacramento v. WCAB, 65 C.C.C. 1 (2000) and Weatherall v. WCAB, 66 C.C.C. 798 (2001). In this case, an applicant stipulated there was no cumulative trauma when, in fact, that was really the only basis of establishing industrial injury. The Workers' Compensation Appeals Board set aside the stipulation after the trial, but the Court annulled this decision, stating this was an abuse of discretion, and remanded the case to consider whether there was actually good cause to set aside the stipulation. On remand, the Board found that the judge made a mistake (this was actually a stretch), and used this as a basis to set aside the stipulation, but the Court of Appeal again disagreed, finding that good cause to set aside the stipulation was not shown, that it was therefore binding, and that applicant takes nothing.

Finally, in connection with the production of evidence, Labor Code § 5703 should be noted, in that it allows excerpts from expert testimony received by the Appeals Board in connection with similar issues of scientific fact in other cases, where that testimony is set forth in the prior decsisions of the Appeals Board.

VI.

LIENS

Quite frankly, the subject of liens is not really extensively discussed during these conventions. Normally, lien issues and litigation occur after applicant's cases in chief have been

resolved one way or another, so most applicant's attorneys have very little interest in these particular issues. In their "most important case" discussion, the case of Sierra Pacific Industries v. WCAB (Chatam), 71 C.C.C. 714 (2006) was briefly discussed as standing for the proposition that SB 899 works a substantive change in the law, and its provisions make the ACOEM Guidelines retroactive so as to apply medical treatment decisions which occurred prior to SB 899's effective date (April 19, 2004) (to the extent that these decisions remain at issue). The seminar materials stated, "now doctors are victims", which, quite frankly, appears to be a rather mindless statement, especially as it relates to this case, in which a chiropractor ran up an almost $12,000.00 bill in connection with what was primarily a head injury, (this following an emergency room discharge where the emergency room physicians did not feel that any further follow up medical care was necessary). "Victims" such as this chiropractor were responsible for the wildly escalating medical costs in workers' compensation which eventually resulted in the reforms leading up to SB 899. Instead of sympathizing with these people, applicant's attorneys should be telling them that cases such as Sierra Pacific serves them right.

Which leads us to our point, and that is that the Association seems to miss the really important thing about this case: this case is not about applicants at all; it is about lien claimants, and the true impact of this ruling probably extends far beyond retroactive application of the ACOEM Guidelines to self-procured treatment decisions which might have more to do with padding bills than curing or relieving. That is why *Amicus Curi* on behalf of the chiropractor in this case read like a Who's Who of lien claimant representatives in the State of California. Lien claimants realized that this case could serve as a basis for argument that many of the additional restrictions on medical care set forth in SB 899 (pharmacy and surgical center fee schedules, numerical limitations on the amount of treatment, etc.), if not directly regulatory of self-procured care which had been rendered and was at issue after the effective date of SB 899, would at least be considered persuasive with respect to

what was considered reasonable (as you might imagine, the chiropractor's bill was pretty much gutted as a result of the guidelines).

Already, we have cases such as Garman v. WCAB, 7 W.C.A.B Rptr. 10026 (2004), again dealing with a chiropractor who wished to continue administering indefinite treatments with respect to a pre-January 1, 2004 injury, in which the Board held that the 24 treatment limitation set forth in Labor Code § 4604.5 (d) (1) was at least persuasive and could be considered in determining the reasonableness of proposed chiropractic treatment. In Roberson v. Atlantic Mutual Insurance Company, 34 C.W.C.R. 190 (2006), a Board panel found that the new surgical center fee schedule which became effective on January 1, 2004, was persuasive and could be considered as evidence of reasonableness with respect to a surgical center facility fee generated prior to January 1, 2004.

There was a time where lien claimants were given some deference at the Board (in connection with a Lien Trial conducted by the undersigned, the lien claimant actually argued to the judge that the Board had historically given lien claimants the benefit of the doubt in connection with decisions regarding the reasonableness and necessity of their services). We think we are beginning to see some change in this attitude, since it is clear that some of the more reasonable applicant's attorneys, as well as some of the more reasonable judges, believe that lien claimants have played a large role in bringing the system into disrepute. Quite frankly, in the case of a head injury, there is really no excuse for a $12,000.00 chiropractic bill.

VII.

PENALTIES

Penalties could become very significant in connection with the Administrative Director's

new regulations with respect to administrative penalties (Regulation §§ 10225, et seq.). It appears these regulations became effective as of January 1, 2007 and are directed toward "course of business" type offenses, which are actually defined in the loosest of ways: any carrier or third party administrator who has had more than one penalty award issued against it by a workers' compensation judge on or after June 1, 2004, based upon conduct occurring after April 19, 2004 (Regulation § 10225.1 (a)). Workers' Compensation judges are required to report these penalties to the Administrative Director, and once an insurer or third party administrator has 2 or more, the regulations suggest that an automatic audit is triggered. If the audit determines that the carrier or third party administrator knowingly violates Labor Code § 5814 (the unreasonable delay statute) with a frequency that indicates a general business practice, administrative penalties can range as high as $400,000.00. Administrative Director Carrie Nevans, as one of the panelists, suggested that the regulations are based upon the assumption that 2 penalty assessments under Labor Code § 5814 within a 5 year period of time tend to show a pattern.

What makes things worse is the zealot attitude being advocated by a number of applicant's attorneys: do not settle penalty claims, try them all so as to pepper carriers and administrators with administrative audits and penalties. We would like to think that most productive applicant's attorneys would have better things to do (such as serving their client's interests), but, unfortunately, there are going to be some which cause trouble.

It is something that we all need to be vigilant about.

In passing, the case of NUMMI v. WCAB (Gallegos), 71 C.C.C. 1037 (2006) stands for the proposition that, where an underpayment is brought to a defendant's attention, and the defendant investigates, pays what is owed, and includes a 10 % self-imposed increased (probably within a reasonable period of time of being informed of the problem; in this case, it was 47 days), an applicant is no longer entitled to a 25 % penalty, but is restricted to no more than 10 %.

VIII.

MISCELLANEOUS

Two rather important psychiatric cases were discussed in connection with the general requirement that industrial causation must be predominant in connection with the psychiatric disability. In Sonoma State University v. WCAB (Hunton), 71 C.C.C. 1059 (2006), the court dealt with a rather interesting attempt by the Workers' Compensation Appeals Board to apply a liberal construction to the predominant cause requirement of Labor Code § 3208.3: although an applicant might have pre-existing psychiatric disability, and the industrial component of applicant's overall disability was less than predominant, the Board found it was not applicant's overall psychiatric disability which was referenced by the Code section, but rather whether there was actually a psychiatric injury, and whether industrial causation was predominant in connection with that psychiatric injury. This was an interesting concept, but the Court of Appeal rejected it as being inconsistent with the intent behind Labor Code § 3208.3, that legislative intent being to limit psychiatric claims.

On the other hand, in Matea v. WCAB, 71 C.C.C. 1522 (2006), applicant had been employed by the employer for less than 6 months, when a rack of lumbar fell on top of him causing both orthopedic and psychiatric disabilities. The court held that the 6 month employment threshold did not bar applicant's psychiatric claim, since a load of lumber falling on top of an applicant was without a doubt a sudden and extraordinary event.

A significant case with respect to a rapidly disappearing issue is Gamble v. WCAB, 71 C.C.C. 1015 (2006), which held that vocational rehabilitation maintenance benefits were not the same as temporary disability, and that a defendant was thus not entitled to credit against this benefit for wages earned by applicant while he was participating in rehabilitation (applicant had been concurrently employed at the time he was injured, and managed to continue working at his

concurrent employment while participating in rehabilitation). The idea was that an applicant should not be penalized for his ambition in holding down two jobs. The situation would almost certainly be different in the case of vocational rehabilitation temporary disability (the so-called delay benefit), which is, for all intents and purposes, identical to temporary disability, and would be subject to the same type of credit (basically, it would be paid as a wage loss type benefit).

A rather strange case addressing potential inconsistencies in the Labor Code §§ 2750.5 and 3352 (h) (and which may have been a frying pan into the fire situation for the employer/home owner) was Mendoza v. Brodeur, 71 C.C.C. 1135 (2006).
In this case, the homeowner hired an unlicenced contractor, who was injured while doing a roofing job. Because he was unlicenced, he was presumed to be the homeowner's employee pursuant to Labor Code § 2750.5. However, since applicant had worked less than 52 hours for the homeowner in the 90 days prior to the injury, he was excluded from collecting workers' compensation pursuant to Labor Code § 3352 (h), and was thus found to be entitled to maintain a tort action against the employer.

In Pettigrew v. WCAB, 71 C.C.C. 1248 (2006), an off duty correctional officer's attempt to analogize his position to that of a police officer when he stopped to render aid at a road side accident on the way to work, and was struck by a vehicle while doing so was rejected. The court found that applicant's ethical duties and responsibilities did not extent outside the confines of the correctional facilities in which he worked, distinguishing cases involving police officers, who were required to wear their uniforms during their commute, and were expected to stop at accident sites to assist during the course of their commute.

A very significant decision in light of Labor Code § 4453 (a) (8) (re-establishing a minimum temporary disability rate of $126.00 per week for post January 1, 2003 injuries) is Signature Fruit Company v. WCAB, (Ochoa), 71 C.C.C. 1044 (2006), standing for the proposition that temporary

seasonal workers are paid temporary disability based upon their seasonal wage during the season, but are not entitled to any indemnity off season when it is established they would otherwise not be working. The Court reasoned that § 4453 (a)(8) did not really set the level of disability, it actually established a minimum wage during a period of presumed earnings, which, but for the injury, would have existed, and that the true disability rate was established by Labor Code § 4653, which referenced the wages defined in § 4453 (a)(8). If it is clear that an applicant would not have been earning wages during the period of time in question, then § 4453 (a)(8) has no application.

Finally, Dominoes Pizza v. WCAB (Kerr), 71 C.C.C. 1387 (2006), reminds everyone that the WCAB has no discretion to deny a change of venue to the place where the accident occurred, or where applicant resides pursuant to Labor Code § 5501.5, assuming the placement of a proper objection. Although, in this case, since the Board which was initially chosen seems to have been more geographically convenient to everyone concerned (including the defendant), it is really unclear why there was such a fight to change the venue to a place which was many miles away from everybody.

IX.

CONCLUSION

We are not going to say that the outlook at this convention was rosy and optimistic, but the "we are all doomed" attitude seems to have given way to resignation, if not acceptance. Money is not going to be as easy to come by as it once was as far as applicants are concerned, but this convention seems to suggest that applicant's attorneys are certainly capable of continuing to establish some level of disability for most of their clients. As a practical matter, the minor strain and sprain type injuries which, in real life, would be gone in a couple of days, are going to find the present rating system to be rather unreceptive to claims of permanent disability, and it is appropriate that these claims be weeded from the system.

We anticipate that, in the more serious cases, where applicant's attorneys feel that the AMA Guides do not appropriately address applicant's disabilities, attempts will be made to establish disability in connection with associated medical conditions (i.e., sleep disorders and psychiatric conditions as a consequence of orthopedic injuries), or escaping from the Guides entirely by arguing the applicability of vocational evidence.

We do expect, however, to see an increasing focus on medical care, since the potential for medical care is seen as a method to increase the eventual settlement value of cases. This means, of course, that applicant's attorneys are probably going to focus more on Compromises and Releases than they have in the past, and this is probably a good thing from defendants' standpoint.

We would be more than happy to speak with your offices with respect to any of the topics covered in this report, or any other topics in which you may have interest. As always, should you have any questions or require any information, please give us a call.

Very truly yours,

BENTHALE, NICHOLAS & McKIBBIN

By: MICHAEL K. McKIBBIN
Attorney at Law

MKM/kda