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THE DEFENSE PERSPECTIVE AND OBSERVATIONS OF THE CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION 2009 SUMMER CONVENTION

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2009 SUMMER CONVENTION OF THE CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION JUNE 25-28, 2009

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I.

INTRODUCTION

To our clients:

The California Applicants' Attorneys Association held their 2009 Summer convention June 25-28, 2009, and we were in attendance. What follows is a report of our observations and impressions.

The landscape in the field of workers' compensation has been changed dramatically since the last convention, and, to an extent, the system has almost been shaken to its foundation. What's amazing is that it is debatable whether the cases actually responsible for this intense shaking are still good law. The cases in question are the consolidated en banc decisions of Almaraz v. Environmental Recovery Services/Guzman v. Milipitas Unified School District, 74 C.C.C. 201 (2009) and Ogilvie v. City and County of San Francisco, 74 C.C.C. 248 (2009), which, in the minds of most applicant's attorneys, essentially eviscerated the two primary underpinnings of the 2005 Permanent Disability Rating Schedule: the AMA Guides 5th Edition (Almaraz/Guzman), and the diminished future earning capacity adjustment (Ogilvie).

We say the present effect of these cases is debatable because the ink was barely dry when the Workers' Compensation Appeals Board granted reconsideration with respect to all three decisions for the stated purpose of allowing further briefing in the workers' compensation community at large (the briefing schedule has now ended, and we assume that new decisions will be coming in the near future). In granting reconsideration, the Board did not stay the effect of its prior decisions, although the effect of this is unclear.

Applicant's attorneys equate the situation to one where the Court of Appeal grants a writ in connection with an en banc decision. In such a situation, absent such a stay by the Court of Appeal, workers' compensation judges generally consider themselves bound by the en banc decision, at least until the Court of Appeal makes a decision. The reasoning behind this is that the en banc decision still, technically, exists.

From a defense standpoint, we consider reconsideration to be different: when the Workers' Compensation Appeals Board granted reconsideration, we think the effect on the prior three decisions was the same as the granting of reconsideration with respect to a trial court decision: the decision ceases to exist, and has no binding effect until reconsideration has been decided. We think that's a fine, valid, and esoteric argument, but applicant's attorneys reject this approach (naturally), and, as far as we can see, judges are certainly allowing parties to pursue the Guzman/Almaraz/Ogilvie analysis. In a manner of speaking, despite the Workers' Compensation Appeals Board's subsequent action in granting further reconsideration, the "door has been opened", opened very wide perhaps, and cases are flooding through it.

We do know that Governor Schwarzenegger wrote a letter to the Workers' Compensation Appeals Board shortly after the issuance of the decisions, decrying the decisions as undermining his workers' compensation reforms as embodied in Senate Bill 899. This possibly plays into the Board's reason for the further reconsideration, although one observation has it that the Workers' Compensation Appeals Board was somewhat surprised at the wholesale attempt by applicant's attorneys to apply the decisions to a multitude of cases, where the Board's actual intent was to simply establish a roadmap for rare and relatively few exceptions to the use of the permanent disability rating schedule (although, given the sweeping nature of their decisions, why there should have been any surprise at all is itself surprising; restraint has never been a hallmark of California workers' compensation.)

Certainly, there is ample precedent for rebutting the permanent disability rating schedule given appropriate circumstances. It's been done for years in connection with the multiple schedules which preceded this one, with the courts recognizing that the schedules adopted pursuant to Labor Code §4660 were not "absolute, binding and final", (Universal Studios, Inc. v. WCAB (Lewis), 44 C.C.C. 1133 [1979]), but were rebuttable where it could be shown that the schedule did not demonstrate an injured worker's true disability (Glass v. WCAB, 45 C.C.C. 441 [1971]). Perhaps the most recognizable case in this regard is LeBouef v. WCAB, 48 C.C.C 587 (1983), where a lower scheduled rating under the schedule was rebutted by a medical opinion that applicant was incapable of returning to the open labor market because his disability prevented him from participating in vocational rehabilitation. To a certain extent, prior schedules were routinely rebutted by the parties' use of so-called unscheduled work restrictions (much of this occurred in connection with the rating

of upper extremities), used because the permanent disability schedule did not adequately describe or cover the particular disabilities at issue. It is also well settled that the Workers' Compensation Appeals Board is empowered to make disability determinations based upon a review of all evidence, which might not necessarily reflect the actual ratings derived from a schedule (essentially, a range of evidence determination). See Liberty Mutual Insurance Company v. IAC, 13 C.C.C. 267 (1948).

The driving consideration here is the fact that a strict interpretation of the AMA Guides sometimes results in ridiculously low ratings, the classic example being the 0% disability on a career ending injury. In Hyatt Regency Hotel v. WCAB (RossFoote), 73 C.C.C. 524 (2008), an applicant sustained career ending industrial injuries to his right wrist, elbow, left shoulder, and right knee. The primary problem here related to the applicant's very significant grip loss, although a strict reading of the AMA Guides (which was the position of the defense) resulted in a zero rating. In allowing a rating based upon grip loss, the court noted that allowing a zero disability rating for an injured worker with significant grip loss who was unable to resume his occupation rebuts the contention that the AMA Guides adequately considered applicant's condition and impairment.

Quite frankly, as long as strict application of the Guides produces results such as this, the Board and the courts are going to find ways to rebut them, and the defense may not be doing itself a service by blindly insisting on the zero or minimal ratings that a strict application of the Guides produce in such cases. On the other hand, applicant's attorneys now feel that they have a license for wholesale deviation from the Guides, taking the position, essentially, that a doctor can use clinical judgment to deviate from the Guides whenever he feels this to be appropriate. We saw a few of the panelists advocating restraint with respect to the use of Guzman/Almaraz/Ogilvie, probably realizing that an apparent ash-canning of the Guides and the DFEC could well create a distasteful backlash, either short term (case law severely limiting the ability to rebut the schedule) or long term (another wholesale reform for the purpose of tightening up SB 899).

Quite frankly, because this schedule, like previous schedules, is deemed prima facie evidence of disability (and thus creates a rebuttable presumption of the extent of disability determined in accordance with the schedule), we can probably expect that the holdings in Guzman/Almaraz/Ogilvie will not be vacated entirely. We would be somewhat surprised if they were not limited to make it clear that the 2005 Permanent Disability Rating Schedule, and the components upon which it is based, are the "general rule", and deviations from it are expected to be

rare, and applied only in those cases where strict application of the schedule would result in manifest inequity and unfairness. Of course, we will probably be fighting over those terms for years as well.

That is not to say that Guzman/Almaraz/Ogilvie are the only things happening out there. The defense has received favorable opinions with respect to rehabilitation and apportionment, and, all in all, the last five months has been quite a ride. Let's take a more in depth look at what's going on.

II.

REBUTTING THE PDRS BY WAY OF THE AMA GUIDES

Almaraz v. Environmental Recovery Services. Applicant injured his back, with resulting surgery at L4-5, residuals of which prevented him from returning to his usual and customary work as a truck driver and, according to the Agreed Medical Evaluator, realistically limited him to light work. His permanent disability rating under the 2005 permanent disability schedule was 17% before apportionment, based upon a DRE III classification (under the old schedule, this rating would have been 58%, before apportionment). Applicant petitioned for reconsideration, arguing that blind application of the AMA Guides was an error, and should be deemed rebuttable. State Compensation Insurance Fund did not file a reply.

Guzman v. Milpitas Unified School District. Applicant suffered a cumulative trauma injury to the bilateral upper extremities (essentially, carpal tunnel syndrome), which the Agreed Medical Evaluator, Steven Feinberg, M.D. (who has written a paper on this topic, based in part on the opinions he expressed in this case) felt resulted in a 25% loss of applicant's pre-injury capacity (functional capacity) in performing various tasks, and he felt applicant was precluded from returning to her former occupation. Under the 2005 permanent disability rating schedule, she received a 12% rating (if Dr. Feinberg's functional capacity measurement had been used, the adjusted rating would have been 39%).

The essential holding of the Board was that "an impairment rating strictly based on the AMA Guides is rebutted if such an impairment rating would result in a permanent disability award that would be inequitable, disproportionate, and not a fair and accurate measure of the employee's permanent disability." The Board noted that Labor Code §4660(a) requires consideration of the AMA Guides, however, it does not make the guides determinative of the impairment, and that the AMA Guides portion of the 2005 permanent disability rating schedule is thus rebuttable.

From this, applicant's attorneys now contend that Labor Code §4660(a) requires only "consideration of the AMA Guides", but that's not really what the statute says. It's not a suggestion. Labor Code §4660(d)(1) specifically states that "the nature of the physical injury or disfigurement shall incorporate the description and measurement of physical impairments in the corresponding percentages of impairments published in the American Medical Association Guides to the evaluation of permanent impairment (5th Edition)." (emphasis added). Labor Code §4660(d) also provides "the schedule shall promote consistency, uniformity, and objectivity."

So, what we actually have, we think, is mandatory use of the Guides, rather than suggested use of the Guides, but that the result may be rebutted assuming the circumstances for this are appropriate.

What is appropriate? According to Almaraz/Guzman, a rating which is "inequitable, disproportionate, and not a fair and accurate measure of the employee's permanent disability." We are convinced this does not mean differences of 5%, 10%, or maybe even 25% between guide ratings and rebuttal ratings (again, although specific circumstances are probably going to have to be considered). We're talking about something which is truly inequitable, unfair, and perhaps even shocking. The Board specifically noted that physicians are not permitted to deviate from the AMA Guides simply to achieve a more desirable result, and that its decision does not stand for the proposition that the Guides may be disregarded simply to obtain a better outcome (acknowledging this, CAAA's own seminar booklet states the decision "allows the physician to go outside the guides whenever they can justify it", pretty much demonstrating that restraint is an unknown concept).

The real benchmark here may be whether an injury is, in reality, career ending (and we're not sure whether the traditional QIW analysis can be applied in this regard since, in the days of rehabilitation, doctors routinely found applicants who did not want to return to work QIW). A fairly recent example is Ferras v. United Airlines, 37 C.W.C.R. 99 (2009), a panel decision in which applicant sustained an industrial leg injury which resulted in significant lifting restrictions, but no rateable impairment under chapter 17 of the AMA Guides (the chapter relating to lower extremities). Taking into consideration applicant's activity restrictions, the Board awarded disability by analogizing the impairment rating for a hernia, which addressed the specific activity restrictions applicable to applicant's conditions (the table was in chapter 6, relating to hernias). Again, this case

presents the problem where strict application of the guides results in a 0% impairment rating when there is, in reality, significant disability.

A question which was raised with respect to the Ferras case, however, is whether this case (or even Dr. Feinberg's evaluation of applicant's disability in Guzman) represents a true rebuttal or deviation from the Guides. In other words, what is a pure rating under the Guides? For example, if the person has a knee injury, what standard should actually be used here? Is the standard strictly the table relating to the knee, or is the intent of the AMA Guides to measure the impact on the entire lower extremity, or even entire body system? If viewed in the latter sense, then perhaps Guzman and Ferras are not really deviation cases at all, since both of these cases are producing ratings which seem to "incorporate the description and measure of physical impairments and the corresponding percentages of impairments published in the AMA Guides". Chapter 1 of the Guides specifically permits analogies where a physician does not feel that the impairment is adequately addressed, so who's to say that the analogies set forth in Guzman and Ferras are not actually "incorporating the descriptions and measure of physical impairment and the corresponding percentages of impairments" in the AMA Guides. It is entirely possible that we're not dealing with rebuttals of the AMA Guides here at all. For example, in table 6-9 of the Guides, relating to hernias, a functional disability precluding heavy lifting warrants a 10% - 19% impairment, while we have seen tables 13-2 used (consciousness or awareness disorders) in connection with headache or post traumatic head syndrome type disabilities.

What we have some difficulty understanding is the aversion of the panelists to the GAF method of rating psychiatric disabilities. They tell us it is not the GAF scale itself which bothers them so much, as the conversion table, arguing that, for social security purposes, a GAF of 50 will generally qualify a person for benefits, as it is assumed they are unable to keep a job. Quite frankly, in most of the cases we have seen so far, the GAF results in a higher disability rating than the old work function impairments, primarily because the GAF does not necessarily require work function impairments (in other words, the fact that a person has panic attacks on an intermittent basis, perhaps in response to certain stimulus, will result in a GAF in the 50s, even if that person is otherwise well adjusted, and not affected in the job at all).

This brings us to another matter, which is the Guzman/Almaraz observation a more appropriate rating may be used if the AMA impairment is disproportionately high. There is no reason why the general rule with respect to ratings (where a rating is not rationally related to the applicant's diminished ability to compete on the open labor market, then the rating is arbitrary, unreasonable, and not supported by the evidence in light of the entire record, Duke 204 Cal. App. 3d 455, an old schedule case) can not be applied to a disproportionately high rating, and Guzman/Almaraz specifically states that AMA ratings should not be followed where they are inequitably high. The panelists suggested that it was the intent of the Guzman/Almaraz Board that the AMA guides should actually be the floor (baseline) impairment, but the Board clearly did not say that, and specifically stated that its analysis would apply in appropriate cases where the resulting impairment rating was inequitably high.

More than likely, we won't see anything like this in orthopedic cases, but applicant's attorneys are genuinely concerned with respect to non-orthopedic disabilities such as cardio-vascular disabilities (and, quite frankly, we have seen the GAF result in some ridiculously high psychiatric ratings as well). At least with respect to the cardiovascular type of injuries, applicant's attorneys argue that the reason these impairments are so high is, essentially, because of the potential for serious and/or life threatening disability. Again, however, if applicant's attorneys believe that each case should stand on its own merit, we think it's somewhat hypocritical that they carve out an exception for all cases which may be beneficial to employers.

One final note: even if it is eventually held the rating by analogy method (utilizing the tables which describe the functional limitations rather than those which are strictly limited to the involved body parts) may be actually incorporating the descriptions and in measurements of physical impairments described in the Guides as required by statute, we think violence is certainly done to the second prong, describing the purpose of the new schedule as promoting consistency, uniformity, and objectivity.

III.

REBUTTING THE PDRS THROUGH THE DFEC ADJUSTMENT

Ogilvie v. City and County of San Francisco, 74 C.C.C 248 (2009). Applicant, a transit operator, sustained multiple orthopedic injuries, underwent extensive knee surgery, and declined the recommended back surgery. This was a career ending injury. Strict application of the AMA guides resulted in a permanent disability rating of 28%, valued at $26,700.00. Applicant challenged the rating based on an argument that it did not accurately reflect her diminished future earning capacity, and vocational experts were retained by both sides (this is always a somewhat dangerous scenario, where a relatively highly paid employee, with not much by way of transferable skills, sustains a career ending injury and has no prospects of returning to employment at anywhere near the prior wage, yet the disability money is relatively low). The experts found earning capacity loss of over 50%, which the trial judge found translated into a permanent disability rating of 40%, and we were off to the races.

The en banc Workers' Compensation Appeals Board found that the DFEC portion of the Permanent Disability Rating Schedule (the future earning capacity adjustment table located at pages 2-6 and 2-7 of the January, 2005 schedule booklet) is rebuttable, but rejected the concept that a permanent disability rating could be based upon how closely the amount of an injured employee's lost earnings correspond to permanent disability indemnity on a money chart (basically, the thrust of most vocational expert testimony we have seen to date on the issue). The Board suggested that vocational experts were not necessary for the purpose of making the calculation which would determine whether or not the standard adjustment factor was rebutted, stating the use of such experts for that purpose to be a process too expensive and cumbersome, and instead suggested a "simple" mathematical computation. Even those attorneys who do understand the computation concede that it took multiple readings of the case to finally understand it. The Board suggested the calculation is based upon the Rand study, which was the basis for the standardized adjustment factors in the schedule's table. By way of a hypothetical example, using real numbers, it works something like this, utilizing these three assumptions: a WPI of 10%; a three year post injury earning history for applicant of $50,000.00; and a three year earnings history of similarly situated employees without injury (the control group) of $100,000.00.

1. Subtract the employee's three year earning history from the control group earnings ($100,000.00 minus $50,000.00) to determine the employee's actual earnings loss of $50,000.00.

2. Divide the employee's earnings loss by the control group earnings ($50,000.00 divided by $100,000.00) to determine the proportional earnings loss (50%).

3. Divide applicant's WPI by the proportional earnings loss (10% divided by 50%) to determine the DFEC ratio (.2%).

4. Compare the DFEC ratio (.2%) to the adjustment table in the guide. If it does not fit within the range of ratios within applicant's designated occupational rank (the DFEC ranks set forth in the table), then applicant will be placed in the rank which appropriately encompasses her ratio. In this case, applicant's ratio is less than anything within the table (0.450 through 1.810), so the table in its entirety has been rebutted, and we can go to the next step.

5. Divide the highest ratio in the range by applicant's DFEC adjustment (1.81 divided by .2 equals 9.05), then multiple that result by .1 and add 1 (9.05 times .1 equals .905 plus 1 equals 1.905), and this is the new DFEC adjustment factor.

6. Multiply the new DFEC adjustment factor by applicant's WPI to calculate your standard rating (1.905 times 10% equals 19%, and then adjust for age and occupation).

Here are the terrible problems involved with the formula:

1. The only assumption referenced above which may be subject to relatively easy calculation is the WPI, and even that may be difficult since applicant's attorneys are telling us that Guzman/Almaraz is going to be the first step in the ratings calculation, before we even get to Ogilvie.

2. The employee's three year post-injury earning history assumes we have an applicant who is motivated to return to work. In the case of a depressively large number of applicants with litigated cases, we think that assumption is seriously incorrect. Some years ago, we became involved in the defense of a case with a well known applicant's

attorney, whose game (among others) was to set traps for carriers so as to later be in a position to make a claim for astronomical amounts of retroactive rehabilitation temporary disability. Our involvement in this case came too late for us to do anything about the trap, except lament what his client, with his catastrophic 15% back sprain, had been doing for the past five years. The reply: "He's been sitting on the couch, drinking beer, watching T.V., letting his wife support him, just waiting for the big retroactive check that your client is going to write." Said with a laugh, and a somewhat patronizing "Be grateful; guys like me are why you're employed."

Actually, the complexity of the system is such that there is probably more than enough work for everyone involved in it without this type of gamesmanship. The point, however, is that there appear to be a significant number on the applicant's side to whom the collection and maximization of benefits, rather than actual healing and return to work, is the primary goal. And, if we suddenly have a formula which increases the multiplier the longer people stay out of work, this problem is only going to be exacerbated. The Board recognized that individual employees should not be able to manipulate the proportional earnings loss calculations through malingering or otherwise minimizing their post injury earnings, but they really did not propose any type of adequate solution for dealing with this problem (consensus at the convention was that there was going to be a big increase in sub rosa).

3. The control group. Although the Board seemed to think that representative wage information can be obtained from the Employment Development's website, or similar sources, the panelists were pointing out it is not quite that easy, and perhaps not that accurate either. A huge company, with a large enough representative sample of employees in the same occupation as applicant, may be able to provide generic information in that regard with respect to one of its injured employees, but we think most employers involved in workers' compensation really are not in a position to provide such a representative sample.

4. Even some of the CAAA panelists are critical of Ogilvie, thinking that it represents a continued misunderstanding by the Workers' Compensation Appeals Board of the purpose of the diminished future earning capacity adjustment (designed to link the non empirical AMA Guides impairment percentages to the underlying empirical data on diminished future earning capacity). The materials say that the DFEC adjustment does not measure either impairment or diminished future earning capacity, but it instead measures the mathematical relationship between those figures.

Quite frankly, we are not quite sure how this justifies the system rejected by the Ogilvie board (determine the percentage of lost future earning capacity, and that represents the standard rating). Among current panelists who still believe the old approach to be better, there appears to be a consensus that, despite the Board's suggestion that its formula significantly limits the use of vocational experts, experts are now going to be required more than ever for the purpose of determining the appropriate control group earnings, as well as providing realistic assessments of an applicant's earning capacity when there are suggestions that he is attempting to minimize earnings.

5. Applicant's attorneys are concerned here as well that Ogilvie could well result in a reduction of the impairment rating, especially in situations involving relatively high paid employees who are motivated to return to work (the most common examples would be police officers and firefighters, although the list is certainly not limited to such public safety officers). Application of the formula would result in a numerical increased earning capacity, which would tend to push the whole person impairment percentage down. Thus, we actually have a rating system which penalizes the honest employee.

Unlike Almaraz/Guzman, where there is acknowledgement that many of the cut and dry, routine cases will still be rateable by strict reference to the AMA Guides, there is absolutely no reason (we think) that the Ogilvie calculation would not be performed in every case, either by applicant or the defense. Why not? Intended or not, Ogilvie has essentially stripped the DFEC table of its presumptively correct status, and simply turned it into a guide, much like the multiple disability and combined disability tables or guides (but which can be confirmed by specific mathematical formulas). If the goal of the new permanent disability schedule was predictability and objectivity,

application of the Guzman/Almaraz analysis, followed by individualized diminished future earning capacity calculations have pretty much made that goal unattainable.

Perhaps only to a point, however. A rather interesting anomaly about the Ogilvie case is that the effect of it is minimized as the impairment rating approaches 45%. After an impairment rating exceeds about 45%, the Ogilvie formula no longer creates a variance in the DFEC adjustment.

IV.

APPORTIONMENT AS BETWEEN INDUSTRIAL INJURIES (BENSON)

Almost lost in the Almaraz/Guzman/Ogilvie tidal wave was the significant decision of Benson v. WCAB, 74 C.C.C. 113 (2009), wherein the District Court of Appeal interpreted the new apportionment statutes requiring apportionment to causation as requiring that each distinct injury be evaluated in connection with the disability caused by that injury, rather than combining permanent disability under the old Wilkinson v. WCAB, 42 C.C.C 406 (1977) rule. What was significant in Benson was the nature of the two injuries involved, since they involved the same part of the body, occurred pretty much contemporaneously (a specific injury, combined with a cumulative trauma injury extending up to the date of the specific injury, both becoming permanent and stationary at the same time). The court still felt that Labor Code §4663's mandate required apportionment with respect to each injury, so the result was two 31% awards, rather than one, combined 62% award.

Utilizing a Wilkinson approach may still be permitted where physicians cannot separate out the percentages with reasonable medical certainty. It is noted that Benson points out that apportionment as between industrial injuries is still the employer's burden of proof, and where a physician can not demonstrate, by substantial evidence, that disability can be appropriately apportioned between separate injuries, the employer will be found to have failed in its burden of proof, and a combined award would probably be permitted.

Benson petitioned for review, but the Supreme Court denied the petition, so this is a final, published case. We do understand there are some DCA cases pending in other districts with respect to this issue, and applicant's attorneys are hoping they will reach different results. However, it is our understanding that the California Supreme Court had several cases pending before it, which cases have now been remanded back to DCA's for reconsideration in light of the Benson decision. This would suggest that the Supreme Court agrees with the rationale.

When does Benson not apply, besides those situations where it's impossible to separate percentages?

a. We think applicant's attorneys are going to reverse an earlier practice of attempting to file multiple injury claims in order to escape the statutory restrictions on chiropractic and physical therapy care (and, earlier, the temporary disability limitations). Those are certainly going to backfire in light of Benson. The push, now, is to question whether there really are multiple injuries, and to perhaps characterize significant disability, in appropriate cases, as being all the result of one cumulative trauma, with perhaps several specifics as being nothing more than "bumps in the road", and simply manifestations of the developing disability in connection with the cumulative trauma. Related to this was the argument that relatively minor industrial injuries did not result in permanent disability until the one major injury which caused work interruption.

b. Compensable consequence injuries are not subject to apportionment. It is settled that those injuries are not considered new and independent injuries, but rather relate to and are part of the original injury (basically, the person injured in an automobile accident on his way to medical treatment in connection with his industrial injury). In State Compensation Insurance Fund v. IAC (Wallin), 24 C.C.C. 302 (1959), applicant had an industrial eye injury, and as a result of the vision impairment accidentally cut off one of his fingers, which was felt to be a compensable consequence of the original eye injury.

c. More on the question of generalized apportionment to non-industrial factors is the question of "risk factors" in connection with particular injuries or diseases. Millivojevich v. United Airlines, 72 C.C.C. 1415 (2007), essentially found that apportionment to "risk factors" was inappropriate since risk factors are characteristics which increase the possibility of disease or injury, but do not actually cause it. There is a rather fine line here of course, which relates to what type of causation we're actually talking about (proximate cause, or so-called "but for" cause.) There are law school examinations on the difference.

There is a defendants practice which is likely to meet some resistance from applicants in the future, and that is the practice of attempting to attribute applicant's disability to events which may have happened at other employers. The seminal case encouraging this is Aetna Casualty and Surety Company v. WCAB (Coltharp), 38 C.C.C. 720 (1973), which essentially held that an applicant actually sustained separate cumulative injuries, where the periods of injurious exposure were characterized by separate periods of temporary disability (the flip side to this case is Western Growers Insurance Company v. WCAB (Austin), 58 C.C.C. 323 (1993), where it was held that separate periods of temporary disability don't matter where there is unbroken and continuing medical care; under these circumstances it is all one injury). Although applicants didn't pay too much attention to these separate filings (other than to complain that they were mechanisms for delay), we suspect that we will see them paying a great deal of attention now, and that they will focus on attempting to place all disability with one injury.

It is suggested that one method of avoiding the harsher effect of Benson is to avoid its even splits of the rating (i.e., a 50/50 split of disability), trying to convince the doctor to load up most of the disability on one injury, with a small amount on the other, as this will minimize the effect. We suspect we will be seeing a lot of treating doctors either doing this, or stating that, with disabilities becoming permanent and stationary at the same time, it is too difficult and speculative to apportion as between them.

We may also be seeing a lot more Subsequent Injuries Benefit Trust Fund cases where Benson is involved as well, whereby applicant's are able to obtain supplemental benefits based upon the cumulative effect of prior injury and disability.

There is, however, a very interesting dovetail here between Benson and Ogilvie (assuming Ogilvie remains good law). If injuries are split apart under Benson, and an Ogilvie analysis is applied to each of the separate injuries (assuming there is a future earning capacity loss ratio which takes applicant outside of the schedule's DFEC table), the actual monetary value of the separate injuries tends to be greater than the monetary value of the combined disability using the same Ogilvie formula (probably because Ogilvie becomes less significant as the rating gets higher, eventually disappearing when the impairment rating reaches about 45%). This, coupled with the fact applicant now has multiple injuries, the disability for which is payable concurrently ($230.00 a week, multiplied by however number of injuries applicant has), actually has applicant's attorneys thinking

that Benson may actually work for them, and it is truly upsetting to them probably only in those cases where the combined ratings would have resulted in a life pension or better.

V.

TOTAL DISABILITY CASES

Since the adoption of Senate Bill 899, applicant's attorneys have complained frequently that it is impossible under the AMA Guides based schedule to obtain a 100% rating in the absence of death. We heard that claim made again during this convention, although the seminar materials actually reference a case, City of Oakland v. WCAB (Cage), 73 C.C.C. 1351 (2008) where a combination of internal medicine type disabilities resulted in an 80% whole person impairment, which in turn resulted in a rated out 100% disability. There are, of course, concessions from applicant's attorneys that internal medicine impairments may well rate higher under the 2005 permanent disability schedule than they did under the 1997 schedule.

That being said, our focus here is on Labor Code §4662, the statute dealing with total disability cases both within and without the schedule, a statute which was left intact by Senate Bill 899 (sub-section [d] underwent a slight amendment in 2007, which did not affect its meaning). Labor Code §4662 reads as follows:

> "Any of the following permanent disabilities shall be conclusively presumed to be total in character:
>
> (a) Loss of both eyes or the sight thereof.
>
> (b) Loss of both hands or the use thereof.
>
> (c) An injury resulting in practically total paralysis.
>
> (d) An injury to the brain resulting in incurable mental capacity or insanity.
>
> In all other cases, permanent total disability shall be determined in accordance with the fact."

For reasons which will be discussed below, applicant's attorneys with total disability cases would like to fit them within the four specifically described categories. In other words, is a person who is legally blind, but still maintains some semblance of vision, totally disabled within the meaning of the statute; is a person whose disability precludes practically any grip one who has lost use of both hands within the meaning of the statute; is a wheelchair confined paraplegic one who would be considered practically, totally paralyzed; is a psychiatric injury an injury to the brain? There are at least several trial court decisions (and a few panels) which suggest the answer is yes to

at least some of these questions and, as a practical matter, most trial judges probably are not going to be favorably inclined to limit benefits to persons with the types of disabilities described in Labor Code §4662. The problem from the defendant's perspective is that we may tend to narrow in on the impairment tables of the AMA Guides, arguing that a case should be rated exclusively pursuant to the permanent disability schedule established by Labor Code §4660. That may be a decent argument, but we should not lose sight of the fact that if an applicant is claiming to be suffering from one of the conditions described in Labor Code §4662, the rating schedule may prove to be irrelevant.

This may also be very true in connection with disabilities not specifically falling within one of the four categories mentioned by §4662 ("in all other cases, permanent total disability shall be determined in accordance with the fact."). There are certainly situations where an applicant is going to be able to establish permanent, total disability where the medical conditions causing that disability are not one of the four conditions specifically described in Labor Code §4662, nor is the disability either a condition or combination of conditions which would rate to 100% utilizing the Labor Code §4660 permanent disability schedule. One of the panelists argued that total disability must be defined in the same manner as it has been by the courts in cases dealing with benefits under non-industrial disability policies (beginning with the California Supreme Court case in Erreca v. Western State Life Insurance Company, 19 Cal. 2d 288 (1942). To a certain extent, the general definition of total disability found in some of these cases (an inability to substantially engage in any gainful occupation by reason of the physical or mental impairment) are similar enough to what we see in workers' compensation, but to suggest (as one of the panelists did) that workers' compensation carriers' deviation from the California common law definition of total disability would constitute bad faith is off the mark. Workers' compensation is not common law; it's a creature of statute, and while analogies to holdings in strictly common law areas may be helpful, they are not necessarily controlling.

The flip side of the coin, however, is that blind adherence to the argument that a case must be determined by the specific ratings authorized by Labor Code §4660, in the absence of a showing that applicant's condition is not one specifically described by Labor Code §4662, is going to get a defendant into trouble. An example is a panel reconsideration opinion in Perez v. Universal Care, Inc., Case No. VNO 0459871 (May 21, 2008), where the defendant appears to have primarily focused upon an argument that applicant's medical reporting was inadmissible because it was not

rateable under the 2005 permanent disability rating schedule. The defendant apparently did not attach much significance to the fact that two of applicant's three medical evaluators (including the primary treating physician) found that the combination of applicant's various, industrial disabilities prevented her from returning to any type of meaningful work, and that she was totally disabled. These opinions were supported by a vocational evaluation expert, whose evaluation led him to believe that applicant was not feasible to return to any type of work either. Both the trial judge and the Board found that this was substantial evidence supporting a finding of total disability. The Board did note that the 2005 permanent disability rating schedule defines "permanent total disability" as a level of disability at which the employee has sustained a total loss of earning capacity. This was equated to a situation where applicant was incapable of returning to the labor market, and the Board specifically noted that since Labor Code §4662 had not been changed by Senate Bill 899, and the schedule was still considered only prima facie evidence, LeBoeuf v. WCAB, 48 C.C.C. 587 (1983) was still good law.

Another example is Odle v. Heintschel Plastering, Case No. SDO 0305611, in which the panel approved the LeBoeuf standard finding that applicant was permanently, totally disabled (although there were unresolved apportionment issues in connection with which the case was remanded), even though the actual rating did not necessarily equate to 100% (more about apportionment later). In Odle, applicant injured his back following an apparent slip and fall, and eventually underwent extensive spinal surgery (various procedures, L1-S1), with pretty much terrible results. This brings to mind a number of panelists we have heard at these conventions over the years preaching the gospel with respect to how to undermine utilization review and the attempts to obtain second opinions so as to enable the free choice primary treating physician to rush an applicant into the operating room for a slice and dice. That's not to say that some of these people don't need surgery; some of them do but, unfortunately, we think many of them don't. A prominent Southern California Agreed Medical Examiner once privately remarked to the parties following a deposition on the issue of medical care that he thought there were far too many surgeries in workers' compensation. In connection with the rush to surgery, we have seen far too many results like the one here in Odle. But we digress.

The difference between permanent total disability found as a result of the application of the four specific conditions enumerated in Labor Code §4662, and permanent total disability found as the result of Labor Code §4662's catch-all phrase (or rating under Labor Code §4660) is apportionment, which is why applicant's attorneys are going to attempt to show that their 100% cases actually fit within one of the four Labor Code §4662 categories. Where the four enumerated conditions referenced in Labor Code §4662 are conclusively presumed to cause 100%, total industrial disability, there is no apportionment, not even to prior awards pursuant to Labor Code §4664 (b). In Kaiser Foundation Hospital v. WCAB (Tremoureux), 71 C.C.C. 538 (2006) (writ denied), applicant sustained a 1989 industrial injury to her wrist in connection with which she received an 18 ¾% Stipulated Award. Subsequently, she sustained additional injuries to the bilateral hands and wrists in 1998, and as the result of a cumulative trauma through the year 2000. Her disability resulted in an 80% loss of grip, and a 75% loss of pre-injury capacity for gripping, lifting, handling and twisting activities, as well as an inability to work in any position requiring gripping or grasping. Her primary treating physician also precluded applicant from handling, writing, typing, and driving, and concluded that applicant's upper extremity disability essentially precluded her from working, and caused permanent total disability. Applicant claimed the benefit of a Labor Code §4662 (b) presumption (loss of both hands or use thereof).

Defendant was at a definite disadvantage here, since their own QME found that applicant was totally disabled, but was of the opinion that applicant's industrial disability was only 81¼%, after deducting the prior award. The trial judge actually agreed with this, and applicant petitioned for reconsideration, which was granted. The judge changed his mind, agreeing that Labor Code §4662 (b) applied, and that apportionment by the subtraction method was improper. The Board agreed that the total effect of applicant's work restrictions was that she had lost the use of both hands, and that applicant was thus entitled to the conclusive presumption. The Board held that although both Labor Code §4662 (b) and §4664 (b) created conclusive presumptions, the conclusive presumption of total disability "trumped", and precluded apportionment of any kind, including apportionment to a prior award. It was noted that this result was supported by language in Labor Code §4664 (c), which prohibits the accumulation of permanent disability awards from exceeding 100% over an employee's lifetime, unless the employee's injury or illness is conclusively presumed to be total pursuant to Labor Code §4662.

Now we see why applicant's attorneys would like to equate psychiatric injuries with brain injuries under Labor Code §4662 (d), although, at least here, the suggestion is that the Board is not ready for such a step. In Sherry v. Connelley's Fine Furniture, Case Nos. OAK 216926 and 207971 (2008), a panel decision on reconsideration rejected the argument that a claimed psychiatric injury was, in reality, an injury to the brain (although, in this case, it was held that the full extent of applicant's disability warranted a 100% award "in accordance with the facts".).

Returning to the panel decision in Odel v. Heintschel Plastering, Case No. SDO 0305611 (2007), even though the panel concluded that applicant was totally disabled (in accordance with the fact), the case was returned to the trial level for determination of the apportionment issue. Prior to his industrial injury, applicant had sustained several heart attacks, had a non-industrial peripheral neuropathy, and a non-industrial back injury, which had also required extensive surgery. The trial judge stated, "apportionment is not applicable when total permanent disability has been determined due to inability to compete in the open labor market", a statement the panel found to be totally devoid of authority and merit. The panel stated:

> "Contrary to the views of the parties and the WCJ, we consider LeBoeuf not only viable law, but reconcilable with both Labor Code §4663 and §4664, as enacted in Senate Bill 899. LeBoeuf is a factor to be considered in arriving at overall disability before apportionment, but it is not a factor to be applied after apportionment and does not preclude apportionment. ... Having determined that applicant was 100% disabled, the WCJ was then obligated by §4663 to address apportionment of permanent disability to factors other than applicant's industrial injury. Defendant has the burden of proof on apportionment."

A fairly recent opinion, Strayer v. WCAB (Senco Construction), 73 C.C.C. 1477 (2008) holds that apportionment among industrial injuries pursuant to Benson is required in cases of non-presumptive 100% disability.

There is a dark suggestion in the Odle decision which suggests that applicant may be 100% industrially disabled, despite his prior orthopedic and internal medicine disabilities, if other factors relating to the industrial injury (i.e., medication intake) were taken into consideration. In Odle, the applicant was taking tons of medication in connection with his industrial injury, and the Board suggested that the effect of this medication on him might warrant an unapportioned, 100% award. This is a somewhat dark cloud in connection with apportionment arguments which the defense frequently makes in connection with consequential injuries (most frequently seen in connection with psychiatric injuries, the argument goes that apportionment of the consequential injury matches the apportionment of the prime injury. So, if an applicant has an orthopedic injury which is deemed 60% industrial, a consequential psychiatric injury would be deemed 60% industrial as well). Panelists are arguing that this is an invalid apportionment, since the psychiatric injury arises only after the industrial injury occurs, and is in direct response to it. We think the implication in this decision is that the Board (at least this panel) may be inclined to give some weight to that logic.

VI.

COLA ADJUSTMENTS

Labor Code §4659 (c) provides as follows:

> "For injuries occurring on or after January 1, 2003, an employee who becomes entitled to receive a life pension or total permanent disability indemnity as set forth in subdivisions (a) and (b) 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."

For reference, the Disability Evaluation Unit, when commuting awards, is assuming an average increase of about 4.7% per year.

Applying this to future life awards (either life pensions or total disability awards) results in some eye-popping numbers. In the case of Loya v. Arrowhead Brass Products, 2008 Cal. Wrk. Comp. PD LEXIS 87 (2008), applicant had an 88% award, which resulted in a life pension payment of $85.04 per week, based upon his earnings. The life pension would not kick in until the year 2017,

but when it did through the end of his life expectancy in 2034, the payment would have doubled to $161.76. Over the course of a lifetime, this could make a difference of 2-3 times the amount of money that an applicant would receive if the cost of living adjustments were not applied. These are especially apparent in the case of total disability awards. Assuming no adjustment, an $840.00 a week payment over a 40-year period would result in a total payout of $1,799,146, with a present day value of $957,470. Applying the COLA adjustment (based upon the 4.7% projection), the $840.00 a week payment steadily increases until, at the end of 40 years, it totals $5,450.40 a week, with a total payout of $5,378,718,. and a present day value of $3,029,299.

These are very significant differences, and the panelists are telling their members to pay closer attention to them. On the defense side, we have a tendency to evaluate these cases without consideration of the COLA increase (we especially succumb to such a tendency when an applicant's attorney goes along with it). This may become a little more difficult in the future.

In connection with awards which are subject to the Labor Code §4659 (c) increase, the primary issues at this time appear to be commencement date and attorney fee commutations. The state of the law appears to be developing differently for life pension cases, as opposed to 100% total disability cases, although the appellate courts have not really definitely ruled on the subject yet.

With respect to life pensions, Loya v. Arrowhead Brass Products, supra, was a panel decision, in which the panel defined the phrase "entitled to receive a life pension" as meaning that the entitlement begins when the first payment is due (which occurs only after the original award of permanent disability has been paid out), so that the annual cost of living adjustments to the life pension would not begin until the January 1st following the first payment of the life pension.

Total disability awards are a different animal, and there may actually be a split of opinion here. In XYZZX SJO2 v. Subsequent Injuries Fund, case number SJO 251902 (2009), a panel on reconsideration considered the Subsequent Injuries Benefit Trust Fund's liability for COLA adjustments in connection with a finding of total disability. The trial judge found that the COLA was applicable on January 1, following the date of injury, and assessed a penalty against SIF for not applying the adjustment as of that date (which is insane, since the date on which these adjustments begin is a bona fide, legal issue which still isn't resolved). The panel affirmed everything (continuing the insanity with respect to the penalty), and this case can actually be read to stand for

the proposition that life pension payments are to be adjusted commencing January 1 following the date of injury as well.

We note the possible conflict here with Monti-Alexander v. State of California, Case No. FRE 0223543 (2008), in which applicant was found to be totally disabled, becoming permanent and stationary on January 12, 2007. The trial judge decreed that applicant was entitled to COLA increases beginning January 12, 2007, but the reconsideration panel amended this decision to provide that applicant's permanent total disability indemnity payments would begin as of January 12, 2007, the permanent and stationary date, and that her COLA increases would begin on January 1, 2008 (the following January 1st, according to the terms of the statute). This, of course, makes the penalty imposed in the XYZZX case even more insane, and appears to reflect a complete misunderstanding by applicant's attorney, the trial judge, and the panel with respect to the definition of "unreasonable delay" (of course, applicant's attorney can probably not be faulted if judges and commissioners are intent on giving away money).

It is the COLA adjustments which have led to the litigation with respect to the commutation of attorney's fees, since applicant's attorneys are becoming sophisticated enough to request that these adjustments be taken into consideration in determining the amount of the fee. In Wilton Fire Protection District v. WCAB (Schneider), 73 C.C.C. 1380 (2008), (writ denied, with the DCA awarding supplemental attorney's fees, finding that there was no reasonable basis for defendant's petition), applicant received a 100% award, and the attorney's fee was commuted, based upon life expectancy tables and, presumably, present day value of the award (although it really does not appear that the cost of living increase was included, although the decision did note that applicant's lifetime PD award was subject to adjustments for state average weekly wages as of January 1, 2008, and thereafter, for permanent disability advances, and that the judge had relied upon life expectancy tables and the regulations in determining the amount of the attorney's fee in the manner of commutation.) Defendant's complaint that the fee should not have been commuted was found to be meritless.

A panel decision, Pan v. State of California, Case Nos. MON 322663 and LAO 850418 (2007), suggests that, in commuting an attorney's fee based upon present day value of a 100% disability award, projected increases in the indemnity rate pursuant to §4659(c) must be taken into consideration.

VII.

PANEL QME PROCEDURES IN REPRESENTED CASES

The long awaited regulations with respect to the issuance of QME panels in represented cases became effective on February 17, 2009 (amendments and additions to Article 3 of Title 8 of the California Code of Regulations, regulation sections 29-39.5). Medical-legal resolution of disputes in cases where an applicant is represented by counsel are essentially governed by the procedure authorized by Labor Code §4062.2, requiring an initial attempt to agree upon an Agreed Medical Examiner, followed by a request for the issuance of a panel of Qualified Medical Examiners for the purpose of evaluation pursuant to Labor Code §4060, §4061, or §4062. The regulations with respect to unrepresented applicants have been in place for quite some time. For the last few years, represented cases have been administered without the benefit of definitive regulations, although analogies were drawn to the procedural requirements set forth in the regulations relating to unrepresented cases, if and when people felt those to be appropriate.

Noteable were the various disputes which arose with respect to time requirements, with some creative parties in the Bay area arguing that the Administrative Director's failure to issue a panel within 15 days pursuant to Labor Code §139.2(h)(1) (which permitted an unrepresented applicant to obtain a medical evaluation from any Qualified Medical Evaluator based on such a failure) entitled represented parties to do the same thing.

That is no more. Regulation 31.1(c) provides that if the Medical Director is unable to issue a QME panel on a represented case within 30 calendar days of receiving the request, the parties may request an Order from the WCAB that a QME panel be issued. There does not seem to be any regulation relating to how this order is to be enforced if it is obtained, and the consensus appears to be that by the time the DOR is filed, and the order is obtained, the panel will have issued in any event.

We listened to one panelist advise that he "walks thru" panel QME requests at the WCAB ex-parte, apparently without notice to the other side, obtaining orders directing the issuance of panels in the medical specialty which he chooses, and he says the orders do not contain objection periods for the defense. We can't see how judges are letting him get away with this, since designation of the medical specialty (especially) is a critical issue, we think. Obtaining such an order ex-parte,

without notice to the defense, and without giving the defense an opportunity to be heard, would appear to be a clear violation of due process.

QME replacement requests are governed by Regulation 31.5, which sets forth multiple reasons for requesting replacement QMEs. One basis for a replacement used to be the late serving of a report, and the game was (in the absence of regulation to the contrary) to see whether one likes the report, and, if not, object to it if it had been served late. This problem has been corrected by Regulation 31.5 (a) (12) providing that such an objection must be made prior to the date the report has been served.

The problem of the unrepresented applicant becoming represented after the issuance of a QME panel seems to have been resolved by Romero v. Costco Wholesale, 72 C.C.C. 824 (2007), which holds that applicant has not "received" a comprehensive medical-legal evaluation for the purposes of Labor Code §4062.1 (e) and §4062.2 (e) until he has attended and participated in the medical evaluation.

Romero, however, does bring up a second problem in the panel QME process, and that is the almost unqualified deference given to the initiating party in the request for a particular medical specialty. In Romero, while applicant was unrepresented, an appropriate panel of three orthopedic surgeons was issued, following which applicant became represented, and applicant's attorney then requested a panel of chiropractors. Aside from the question of why it is considered appropriate that non-medical doctors (or non-D.O.s) should be entitled to render medical opinions with respect to treatment and/or disability. This is gaming the system and, in this case, the judge became an active player by ordering the issuance of a new panel consisting of chiropractors. While we do not dispute that there are good chiropractors out there, the fact that we hear many applicant's attorneys suggest that they will routinely request chiropractor panels (no matter what the injury or disability) because, in their words, chiropractors will give them what they want, suggests we may have far too many bad ones in the workers' compensation system.

The question relates to whether parties (or the system for that matter) are seriously concerned with evaluating the real issues of injury, disability, or treatment. The new regulations with respect to represented workers certainly suggest that the Medical Unit is loathe to utilize any independent judgment with respect to what constitutes a proper medical specialty since the regulations

specifically provide that "the Medical Director shall utilize in the panel QME selection process the type of specialists indicated by the requestor..." (Regulation 30.5), certainly implying that if an applicant's attorney wants a panel of chiropractors on a heart attack case, that is exactly what will be issued. Obviously, questions of whether or not a chiropractor's opinion in a heart attack case would constitute substantial medical evidence exist, but what a colossal waste of time and money, and certainly a perversion of the legislature's apparent intended purpose of limiting the number of medical evaluations.

The only time the Medical Director may actually use some judgment in determining the specialty is under regulation 31.1, where the Medical Director receives two or more panel selection forms on the same day (concurrent requests) requesting panels in different specialties. The regulation suggests that the specialty would default to the specialty of the treating physician (i.e., the chiropractor designated as primary treating physician in a carpal tunnel or even a heart attack case). The regulation does leave some room for discretion, indicating that under such circumstances the Medical Director may select a different specialty if he is "persuaded by supporting documentation provided by the requestor that explains the medical basis for the requested specialty..." and we assume that the documentation referenced is either medical reporting or records. If the parties are requesting a specialty which is not that of the treating physician, then the Medical Director is specifically required to select a specialty appropriate for the medical issue in dispute. Quite frankly, this fallback position should be the primary directive.

We are also aware of the substantial difficulty encountered in attempting to obtain QME panels in different specialties. One alternative was to request the QME to comment upon, or make a referral, to an appropriate specialty, for the purpose of obtaining a medical-legal evaluation in the secondary specialty (i.e., requesting the orthopedic QME to comment upon and, if believed necessary, make a referral for a psychiatric consult). No more. Regulation 32 has been amended to provide that "no QME may obtain a consultation for the purpose of obtaining an opinion regarding permanent disability and apportionment..." with the exception of acupuncturist QMEs (acupuncturist QMEs? How can anyone even pretend that this is appropriate?). Regulation 32 (a) provides that an acupuncturist may request a consultation on the issue of disability (since acupuncturists can not render opinions with respect to disability) and the statute suggests that the manner in which this is to be done is that the request is to be directed to the Medical Director, who will then issue a panel

within 15 days (the convention panelists indicated there is some question as to who is to select the QME from the panel, the acupuncturist or the parties).

Regulation 32 (c) and (d) do indicate that a QME is entitled to obtain a consultation with respect to issues other than permanent disability and apportionment.

Otherwise, the process of obtaining additional QMEs is governed by Regulation 31.7, which provides that the Medical Director will issue a new panel upon a showing of good cause. Good cause consists of an order by the Workers' Compensation Appeals Board, agreement by the parties that there is need for an additional QME in a different specialty, or a recommendation by an Agreed Medical Examiner or Qualified Medical Examiner that an evaluation in a different specialty is necessary, and a representation by the parties that they have been unable to agree.

There is, unfortunately, a terrible trap for defendants in these regulations as they relate to the issuance of panels in denied cases. In essence, once a defendant has denied a case, Regulation 30 (d) essentially provides that the defendant no longer has a right (or the ability for that matter) to request the issuance of a panel of QMEs on the issue of compensability. This has a number of applicant's attorneys practically giddy, and telling their members that the best case may be a denied case, particularly cases which are denied on the basis that there is no medical evidence to support the existence of compensable, industrial injury. The tactic applicant's attorneys will use in such a case is to self procure medical treatment from a typical applicant's evaluator, who will then provide the medical evidence of industrial injury, which a defendant will be absolutely powerless to rebut. A defendant's only hope in such a case is to obtain independent medical records which suggest that the claimed condition originated somewhere other than on the job but, if such medical records can not be produced, a defendant's position would appear to be pretty much hopeless. The most practical approach (since, under the circumstances, a defendant is not going to win at an AOE/COE trial, so the expense in going that route probably can not be justified) would be to admit injury (to as limited extent as possible), and then attempt to obtain an appropriate medical-legal evaluation pursuant to Labor Code §4061 and/or §4062 (with the exception of pure medical treatment regarding admitted industrial injuries, in connection with which defendant's remedy is utilization review).

Even some applicant's attorneys feel that this is a denial of defendant's due process, but as long as the Administrative Director is permitting it, they are going to take advantage of it. Quite frankly, we see nothing in Labor Code §4060 which justifies the limitation on a defendant's discovery set forth in Regulation 30(d). Labor Code §4060(c) specifically provides that "if a medical evaluation is required to determine compensability at any time after the filing of the claim form...a medical evaluation to determine compensability shall be obtained only by the procedure provided in §4062.2." (As to represented cases; §4060(d) references unrepresented cases, and is essentially similar). The only specific event referenced in the section is the filing of a claim form; it says nothing about restricting the application of the section after a denial is issued (we assume the Administrative Director's position is that if the evidence supporting the denial has not been developed within 90 days, or before the denial issues, a defendant is precluded from using it at trial, which we think is in error).

A danger here, of course, is the fact that Qualified Medical Examinations (or Agreed Medical Examinations for that matter) of any kind are rarely completed within 90 days after the filing of a claim form, and, especially in a situation where applicant starts out unrepresented and then, during the panel QME process, becomes represented, it is going to be virtually impossible to comply with the QME timelines set forth in the regulations.

The regulation specifically provides that the only basis for a judge to order the issuance of a QME panel in a compensability case is where the judge has made a finding that presumptive injury under Labor Code §5402(b) has been rebutted [sub-section (d) (4)]. It would appear to us that, at some point, a constitutional challenge is going to have to be mounted against Regulation 30 (d).

There is an issue with respect to whether participation in the panel QME process by a party compromises the ability of that party to rely upon the opinions of the treating physician (thus, perhaps, conveying upon the QME something similar to a presumption of correctness). The contention is perhaps better suited to disputes under Labor Code §4061 (c) and (d), which implies disagreement with the opinions of the treating physician by all parties participating in the AME/QME process. Labor Code §4062 speaks of objections by the parties in the alternative ("if either the employee or employer objects", as opposed to "if the parties do not agree"). The issue is not directly raised in Felix v. Verizon Wireless, 2008 Cal. Wrk. Comp. P.D.LEXIS 459 (2008), a panel decision in connection with which the primary issue was the weight to be given to a QME

opinion as opposed to the opinion of a treating physician. It is not entirely clear what the nature of applicant's participation in the QME process was, but it's implied in the case that applicant did participate in the striking process. The trial judge relied upon the opinion of the panel QME, stating that he was entitled to a legal presumption of accuracy. Applicant petitioned for reconsideration, and the Board stated that the opinion of a panel Qualified Medical Evaluator is not entitled to a presumption of accuracy and carries no more weight than the opinion of the treating physician.

We don't see in this case the argument being made that applicant's participation in the panel QME process reflects a decision on applicant's part to defer to the opinion of the QME (since the QME is being selected in connection with a contest regarding the opinion of the treating physician, why should the person relying upon the treating physician's opinion participate?). Although Felix lent some support to the proposition that a person may participate in the QME process, and still rely upon the opinion of the treating physician, since the issue was not directly raised, we are not sure it has actually been answered.

VIII.

PUBLIC SAFETY OFFICER CASES

A significant portion of this presentation related to disability retirements which, while related to the workers' compensation process, are not generally handled in connection with the regular workers' compensation issues. Briefly, there are three types of retirement systems governed by the Public Employment Retirement System (PERS), the County Employment Retirement Law of 1937 (the "37 Act"), and systems carved out by charter cities. The PERS system is defined and its operation is described by Government Code §20,0000, etc., while the county systems are defined and described commencing with Government Code §31450, etc. Either the employee, or, under some certain circumstances, the employer may file retirement applications. In connection with regular workers' compensation benefits, there is sometimes conflict in cases where a governmental employer is requesting a resignation from an employee in connection with a Compromise and Release. Many applicants are concerned that by resigning their employment, they may be giving up their right to a disability retirement. Government Code §31720, relating to county retirements, specifically conditions the receipt of a disability retirement on the employee not waiving retirement with respect

to the particular incapacity (and it is felt that a resignation of employment may well constitute such a waiver).

Directly affecting regular benefits in workers' compensation are the presumptive injuries set forth in Labor Code §3212 through §3213.2, referencing the following conditions in connection with various, specifically designated safety officers: hernias, heart trouble, cancer, pneumonia, tuberculosis, blood born infectious disease, bio chemical substances, meningitis, skin cancer, Lyme disease, and back trouble.

With respect to the application of these presumptions, there is generally a minimum service requirement, as well as an extended statute of limitations (up to 60 months from separation of service for which the disease to manifest itself, depending upon the length of service), although both periods may be "piggy-backed". In City of San Leandro v. WCAB (Waltman), 71 C.C.C. 262 (2005), applicant was permitted to combine his 28 year employment history with the city of Oakland with his eight year employment history with the city of San Leandro to obtain the statutory maximum time limit ("the legislature intended that the entire period of a retired police officer's regular, full time employment as a police officer be counted in determining the applicability of the presumption."). This piggy-backing, however, is only permitted within the State of California. In Bach v. WCAB (City of Santa Clara), 73 C.C.C. 1590 (2008), applicant was unable to obtain the benefit of a "duty belt" presumption under Labor Code §3213.2, since he had only worked for the employer 22 months (falling short of the five year minimum), even though he had prior employment in New Jersey as a police officer (the rationale was that California had no jurisdiction over New Jersey, so that employment did not count).

Most of these presumption statutes specifically identify the types of safety officers which are subject to the presumption. If an employee does not fit within the specific definition, then the presumption does not apply. See California Horseracing Board v. WCAB (Snezek/ Martin), 72 C.C.C. 903 (2007).

What these presumptions do, essentially, is reverse the burden of proof, imposing upon the employer the burden of proving the non-existence of the presumed fact (i.e., proving non-industrial causation in connection with the claimed injury). The employee has the burden of showing the presumption applies, and thus must show by a preponderance of the evidence that he or she is a

designated employee, suffers from the condition described in the statute, and that it manifested or developed while in the service of the employer (or within the time periods set forth in the statute). If the employee does this, the burden then shifts to the employer to prove non-industrial causation.

How difficult is the employer's burden? It's a very high bar. At least with respect to heart cases, the requirement is that the employer must prove some contemporaneous non-work related event as being the sole cause of the condition. Parish v. WCAB, 210 Cal. App. 3d 92 (1989); Jackson v. WCAB, 133 Cal. App. 4th 965 (2005); Ferris v. IAC, 237 Cal. App. 2d 427 (1965); County of Orange v. WCAB (Sleep), 70 C.C.C. 1499 (2005). A contemporaneous non-industrial event can actually be a series of events rather than just one (Bartholomew v. WCAB (City of San Jose), 63 C.C.C. 842 (1998), cardiomyopathy due to excessive alcohol consumption over a 30-year period).

Applicant's attorneys think that the burden is pretty much impossible to overcome in cancer cases, as Labor Code §3212.1 requires an employer to not only prove the cancer's primary site, but to also prove the absence of a reasonable link between applicant's employment and the cancer. Thus, if an employee has cancer, and he has even minimal exposure to a carcinogen (for example, second hand smoke), that's probably enough. A defendant's only real hope in a cancer case is to prove that the industrial exposure did not occur prior to the latency period. For example, in Law v. WCAB (Contra Costa County Sheriff), 68 C.C.C. 497 (2003), a sheriff's colon cancer based upon exposure to benzene and exhaust fumes triggered the presumption, but the presumption was rebutted because the latency period in connection with cancer from benzene exposure is 15-25 years, while applicant had only 8 ½ years of exposure.

As noted, nothing more than a minimal exposure is required to trigger the presumption (Leach v. West Stanislaus City Fire Protection District, 29 C.W.C.R. 188 (2001). Even where the type of cancer is such that the cause of it is unknown, if there was exposure, the presumption is triggered. Pettit v. City of Anaheim, 67 C.C.C. 1609 (2002).

Applicant's attorneys deem it important to prove that their clients qualify for these presumptions because application of the presumption eliminates an apportionment defense pursuant to Labor Code §4663. Many of the presumption statutes themselves contain so-called "non-attribution clauses", that is, the statute provided that the medical condition referenced in the statute

"so developing or manifesting itself in these cases shall not be attributed to any disease existing prior to that development or manifestation." An amendment to Labor Code §4663 basically applies a non-attribution clause to all of the presumption statutes, so unless apportionment is available pursuant to Labor Code §4664 as the result of a prior award, if a presumption is established, the applicant is entitled to unapportioned disability.

There have been several cases which have actually applied penalties where a statutory presumption exists, and the Board felt that there was no legal basis for denying liability. See Johnson v. WCAB, 50 C.C.C. 71 (1985); County of Sonoma v. WCAB (Herfurth), 62 C.C.C. 1150 (1997).

IX.

OTHER ISSUES

What appears to be a very favorable decision to the defense on the issue of rehabilitation is Weiner v. Ralph's Company, 74 C.C.C. 484 (2009), an en banc decision essentially to the effect that rehabilitation died when it sunsetted on January 1, 2009. The decision is to the effect that, if an applicant did not have a final benefit order in place prior to January 1, 2009, the Board no longer has jurisdiction over rehabilitation issues. What was interesting in Weiner was that the case arose out of a defendant's rehabilitation appeal in connection with a Rehabilitation Unit order for payment of retroactive vocational rehabilitation temporary disability. The rehabilitation appeal was actually tried by the Board in 2008, although the adverse Findings and Award against the defendant did not issue until January 13, 2009. Since there was no final order or award in applicant's favor prior to January 1, 2009, he was out of luck.

We have probably not yet heard the end of this issue, as the matter still has not yet been addressed by the appellate courts. Panelists were of the opinion that, if there is a signed vocational rehabilitation plan in effect as of January 1, 2009, this is a matter of contract, and can be enforced as such. There is also some talk about pursuing vocational rehabilitation as a form of medical treatment, in connection with ACOEM Guidelines which recommend vocational rehabilitation under certain circumstances, but we think this is essentially a pipe dream. If the legislature specifically eliminated the benefit by repealing the statutes, we doubt seriously that the judicial system is going to contravene that intent by implying the existence of the benefit from medical guidelines.

With respect to the statutory limit on temporary disability, there is the somewhat sad case of Brower v. WCAB, 74 C.C.C. 354 (2009), where a significantly disabled applicant in need of further back surgery ran out of his two years of temporary disability, where the Board held that the statute meant exactly what it said: no more temporary disability beyond two years, despite the Agreed Medical Examiner rendering an opinion that applicant remained totally temporarily disabled pending completion of the next surgery. For his predicament, Mr. Brower can probably thank prior applicants, their doctors, and the system itself, which allowed and encouraged applicants with relatively minor injuries to stay off work on temporary disability for years during the days when their free choice treating doctors had the presumption of correctness. The 104 compensable week limit was in direct response to that kind of abuse.

However, in Digirolamo v. Ralph's Grocery Store, Case Nos. ADJ 748314, 2119704 (Grover Beach, May 18, 2009), a panel decision, it was held that where two injuries contribute to applicant's need for temporary disability, one of which being an earlier injury which is not subject to the statutory limitation, Labor Code §4556(b) does not apply, and applicant's right to temporary disability benefits are not time limited.

There was an issue raised that temporary disability with respect to the earlier injury was barred because applicant was beyond five years from date of injury at the time his entitlement to temporary disability commenced. The Board noted that there was no award with respect to the prior injury, and where there is no prior award, the Board has continuing jurisdiction, and is thus able to award temporary disability. We note that there is an unpublished DCA opinion to the contrary but, being unpublished, it is uncitable.

There is still some litigation with respect to what constitutes an amputation. In Murray v. WCAB, 74 C.C.C. 379 (2009), the Board held that the partial removal of a bone projecting from the ankle did not constitute an amputation for the purpose of establishing an exception to the 104 compensable week temporary disability limitation, relying upon Cruz v. Mercedes Benz of San Francisco, 72 C.C.C. 1281 (2007), which essentially held that the exception to the limitation applied only in connection with cases falling within the common sense and ordinary meaning of the word amputation. This, of course, can lead to some absurd results, for example, the amputation of the tip of a finger would entitle an applicant to more temporary disability than the applicant with a failed back in Brower, cited above.

The courts are beginning to pay some attention to the 15% increase/reduction authorized by Labor Code §4658 (b). In Bontempo v. WCAB, 74 C.C.C. 419 (2009), the case proceeded to trial, and applicant did not specifically raise the issue of the 15% increase based upon a failure to return him to work. In reviewing the summary, it did not even appear that there was evidence directly relating to whether or not the city made an offer to return to work, although there certainly was evidence of the fact that applicant had not returned to work with the city. The Court of Appeal held that the 15% increase authorized by statute is an integral part of the compensation package, and it does not have to be raised separately in the Stipulations and Issues. What is of interest here is that the Court of Appeal did not remand the matter back for further proceedings, but actually appeared to step into the role of a trial of fact, and specifically ruled that applicant was entitled to the increase, even though the issue had not been considered below.

The Court used Beckstead v. WCAB, 60 Cal. App. 4th 787 (1997) as a justification, the rationale being that the formal rules of pleading and procedure in workers' compensation are so loose that these types of procedural transgressions by the parties (well, not really by the parties, since if it had been a defendant who missed the issue of the 15% reduction, we're wondering if the result would have been the same) can be overcome. In Beckstead, applicant pled his claim as a specific injury, but it was really a cumulative trauma, and he was permitted to amend his claim "according to proof". In the civil arena, this is not an amendment at all, but is the pleading of brand new cause of action, but who's to notice in workers' compensation?

We think Ornelaz v. Albertson's Inc., 37 C.W.C.R. 74 (2008) is a significant decision based upon the fact that it recognizes the reality of when an employer actually receives notice that an applicant is permanent and stationary. Labor Code §4658(d) makes the 15% increase/ decrease dependent upon action (the giving of notice, rather than the actual fact of work) taken "within 60 days of a disability becoming permanent and stationary..." Many times, defendants do not receive the final reports of the treating or evaluating physicians until all or a significant part of the 60 day period has expired. Ornelas basically holds that the employer's receiving of notice (i.e., receiving the report) is the triggering event, and further holds that, if the report is served by mail, the employer has an additional five days to react to it pursuant to Code of Civil Procedure §10130(a). In this case, it was found that the employee was given notice timely (63days after the date the report was mailed), and the employer was entitled to the 15% decrease.

Just a clarification, however, is Pena v. City of Santa Rosa, 37 C.W.C.R. 102 (2009), a panel decision where it was held that, even assuming a valid and timely work offer, defendant is not entitled to apply the 15% decrease to benefits which were payable prior to the time the written offer of work was given.

MPNs have been a source of trouble for a while, in terms of employers arguing that their employees must use them, and employees arguing that employers are only entitled to insist upon their use if proper notice is given. We have previously written on this subject in terms of the notices which are required at the time of hire, at the time an MPN goes into effect, and at the time of injury. In our practices, we are also aware that many claims professionals feel that the general notice letter, with reference to either a website or a phone number in connection with which the identities of MPN physicians can be obtained, is sufficient. It is not. In Santa Ana Unified School District v. WCAB (Johnson), 74 C.C.C. 68 (2008), it was held that applicant was entitled to self-procure medical treatment outside of the Medical Provider Network where, at the outset of the case, defendant had failed to provide adequate notice of the information required in connection with its MPN, and therefore neglected or failed to provide reasonable medical treatment. In this case, the defendant apparently provided applicant with a notice with respect to the requirement that she treat within an MPN, and provided her with a phone number for use in connection with identifying physicians. This was not sufficient.

In Barrett Business Services v. WCAB (Desiderio), 74 C.C.C. 49 (2008) (writ denied), applicant's attorney requested a list of all MPN physicians within applicant's county of residence. Defendant gave applicant's attorney a website, so applicant self-procured treatment outside of the MPN. The Board held applicant was entitled to a list of all physicians within her county, as requested, and that a failure of the defendant to provide that list (i.e., providing the website is not sufficient) was a violation of the notice requirements set forth in Knight v. United Parcel Service, 71 C.C.C. 1423 (2006).

The lesson here is that if applicant's attorney specifically requests the identity of physicians, he must be given a list, and Barrett suggests that the extent of the list is probably a countywide list.

Barrett also stands for the proposition that, where a claim is denied, an applicant is not required to treat within the MPN, but is entitled to self-procure care for which a defendant will eventually be responsible if liability is determined in applicant's favor.

A significant disappointment for applicant's attorneys was the case of Smith/Amar v. WCAB, 74 C.C.C. 575 (2009), a California Supreme Court decision which held that Labor Code §4607 (allowing an attorney's fee for an applicant's attorney in connection with the defense of a petition to terminate medical treatment) does not authorize an attorney's fee at the expense of the defendant if the defendant does not file a petition to terminate the entire medical award. These cases involved adverse utilization review proceedings, where a treating physician's treatment recommendation was de-certified by utilization review. The Court of Appeal had held that a denial of authorization of medical treatment under these circumstances was the equivalent of a petition to terminate medical treatment, so as to allow an attorney's fee under Labor Code §4607. The Supreme Court held that §4607's language was unambiguous, and that defendant had not instituted a proceeding to terminate an award by relying upon its utilization review. It did note that, under some circumstances, attorney's fees might be payable under Labor Code §5814.5 (award of attorney's fees where there has been an unreasonable delay).

Medicare Set-Aside allocations continue to be a source of discussion, although they were not extensively analyzed this time around. There was some brief discussion with respect to how to avoid them (an award with future medical care, as opposed to a Compromise and Release; stipulating the case, and compromising future medical care for less than $25,000.00 [we're not sure this works: we think Medicare would argue that the value of the settlement should be the combined value of the Stipulation and the Compromise and Release]; Compromise and Release with future medical left open; Compromise and Release for $250,000.00 or less, with a declaration from applicant that he/she has not received nor is eligible for any social security or Medicare; if there are multiple dates of injuries, compromise each one for less than $25,000.00 (not really an exception, but CMS will not review settlements for less than this amount).

There is also the suggestion that the parties do their own allocation, and forego CMS approval. There is really nothing in the regulations or statutes which require the parties to obtain CMS approval for an allocation, since the general tenor of the statutes and regulations is to the effect that the parties are simply required to make a good faith allocation for the purpose of protecting Medicare's interests. A CMS approval simply guarantees that the allocation is sufficient.

X.

CONCLUSION

It's amazing that the primary focus of this convention was driven by three en banc decisions which may not even be on the books anymore. By the time of the next convention, these cases will have been re-decided, and we are assuming that Almaraz/Guzman will probably survive in some form, although we would be surprised if the Board did not make some attempt to limit the reach of those decisions so as to make their application the rare exception rather than the general rule.

We're not sure what's going to happen with Ogilvie. We found it interesting that a number of applicant's attorney panelists did not like the result of that decision, preferring instead the method which was then being developed, i.e., the use of vocational experts to establish a general diminished future earning capacity, and then arguing that the percentage of earning capacity lost should actually be used as a standard rating.

The impact of these three cases, however, which may or may not exist at this point in time is so significant, however, that it completely over-shadowed other very significant decisions with respect to the death of rehabilitation, apportionment in Wilkinson type cases (Benson), and the adoption of the new Administrative Regulations with respect to the use of panel QMEs in represented cases (which may have a significant impact in connection with denied liability cases).

We hope you find our comments, observations, and suggestions set forth in this booklet interesting and useful. If you would like us to arrange seminars or discussions with respect to the topics set forth in this booklet, or any other topics of interest to you, please let us know, and we will be more than happy to make the necessary arrangements.

Until the next time, we remain,

Very truly yours,

BENTHALE, McKIBBIN & McKNIGHT

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