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THE DEFENSE PERSPECTIVE

AND OBSERVATIONS OF THE

CALIFORNIA APPLICANTS' ATTORNEYS

ASSOCIATION

2010 SUMMER CONVENTION

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2010 SUMMER CONVENTION OF THE CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION JUNE 24-27, 2010

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I.

INTRODUCTION

To our clients:

The California Applicants' Attorneys Association held their 2010 Summer Convention between June 24 and 27, 2010, in Monterey, California. We took up our customary position at the rear of the room to observe and report, and what follows is our impression of the direction in which the Applicants' Bar is heading, as well as what we might expect in connection with the further development of the California workers' compensation law. The Applicants' Bar characterizes what has happened over the last six months as a "lull", but we are not so sure. There are some very significant cases which are bottled up in the review process but, in the absence of something truly shocking, it appears the direction in which the law is developing, at least in several important areas, may be fairly predictable at this point.

Of course, there is another gubernatorial election which will take place between this convention and the next one, and whether it is Brown or Whitman could well make a tremendous difference in the direction of the law, as both candidates have suggested that the system needs some additional "tinkering".

In the meantime, the two en banc decisions which dramatically reshaped the landscape of rating cases, Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School District (Almaraz/Guzman II), 74 C.C.C. 1084 (2009) and Ogilvie v. City and County of San Francisco (Ogilvie II), 74 C.C.C. 1127 (2009), are being followed by the trial courts, although all of them are subject to further judicial review. Writ petitions with the Court of Appeal are pending with respect to Almaraz and Ogilvie, and a writ was granted with respect to Guzman, in connection with which oral argument was held on June 10, 2010. The defense began its pitch with the statement that the case involved "chaos and inconsistency", at which time one of the justices immediately interrupted, stating he thought the case involved assuring that injured workers received fair compensation. Assuming that was not the author of the dissent, that comment probably gives us a pretty fair idea of the direction in which this case is going to go.

The infamous COLA case, the Court of Appeal decision in Duncan v. WCAB (XYZZX), 74 C.C.C. 1427 (2009) is off the books, as the Supreme Court has granted a hearing. The Supreme Court generally does not work as fast as the Courts of Appeal, so this issue could be pending for years.

Another significant case, Hertz Corporation v. WCAB (Aguilar), where the Court of Appeal held that environment/cultural factors were a matter of apportionment in what was essentially a Le Boeuf determination, had been accepted for hearing by the California Supreme Court, but that petition has now been dismissed (the reason is unclear; perhaps the parties settled the case). In any event, Rule 8.528(b) of the California Rules of Court provides that, following an Order Dismissing Review, the Court Appeal opinion remains unpublished unless the Supreme Court orders otherwise. The court has not yet ordered otherwise, so the Hertz opinion remains unciteable, although we understand the Defense Attorney Association has requested that the Supreme Court order publication. Quite frankly, we would be somewhat surprised if publication were ordered. Although we thought Hertz reached the right result, we had some questions about the method, and did not really think the concept of "apportionment" was the proper vehicle to reach that result. Hertz was essentially a Le Boeuf-type case, and the question in Le Boeuf has traditionally always been whether or not the effects of the injury itself (apart from non-industrial environmental and cultural factors) renders an applicant unemployable. While the opinions expressed herein are certainly not that of the workers' compensation community as a whole (or the defense community, or perhaps even everyone in this firm; everyone else on the panels was issuing disclaimers, so we might as well too), we always viewed Hertz as an attempt by the Applicants' Bar to expand the Le Boeuf envelope so as to obtain a Le Boeuf-type finding based upon a combination of effects of the industrial injury, and non-industrial cultural and environment handicaps (language, education, etc.). Apportionment really relates to traumatic, idiopathic, or congenital types of physical and/or mental disability. Cultural and environmental factors do not really fit that definition.

So, into this sea of uncertainty, let's see what's happening:

II.

REBUTTING THE PERMANENT DISABILITY SCHEDULE, PART III: LeBEOUF AND OTHER MATTERS

By way of review, Almaraz/Guzman II tells us that the 2005 Permanent Disability Rating Schedule is only prima facie evidence of an applicant's disability, and since it is only presumptively correct, it may be rebutted, that the schedule can be rebutted by rebutting any of its component parts (in this case, the AMA Guides), but since the Labor Code provides that disability shall incorporate the impairments set forth the AMA Guides (Labor Code §4660[d][1]), any rebuttal must still remain within the "four corners of the AMA Guides". That being said, Almaraz/Guzman II holds that "a physician may utilize any chapter, table, or method in the AMA Guides that most accurately reflects the injured employee's impairment".

The starting point in evaluating permanent disability (from the physician's standpoint) is always the strict or traditional approach to the AMA Guides. The issue, at that point, is whether use of such a strict or traditional approach produces an accurate measure of an applicant's disability. Steven Feinberg, M.D., who was the Agreed Medical Examiner in the Guzman case, and one of the panelists at the convention, correctly notes that "the term 'accurate' is not given in any context by the WCAB", and postulates (again, correctly, we think) "that the term 'accurate impairment rating' refers to a relationship between the industrial injury and the permanent effects an objective medical condition has on the injured employee's ability to perform ADLs." He suggests that while the AMA Guides attempt to measure impairment in connection with the effect a condition has on a person's ability to perform activities of daily living, "excluding work", "work activity ADLs" are obviously relevant, and must be taken into consideration.

Theoretically, Almaraz/Guzman II prohibits a physician from utilizing any chapter, table, or method in the AMA Guides simply to obtain a desired result (the example used is the attempt to obtain a permanent disability rating based upon any schedule in effect prior to 2005, but we think the intent of this statement is broader than that, and may be a caution to physicians about suggesting impairments which the physician subjectively thinks are "fair", as opposed to being, perhaps,

objectively "fair"). In other words, whatever is proposed by the physician, in terms of an impairment rating, must be justified by the facts.

This actually brings us to another problem, which is that a lot of people, including the Commissioners who may have gotten lost in the course of those two very lengthy en banc decisions, may not be truly aware of what is actually being rebutted. What is actually being rebutted is the prima facie and presumptively correct disability rating which results from a strict application of the 2005 Permanent Disability Schedule. That is what is supposed to be accurate. Thus, while any component part of the rating can be challenged, in the end, it is the ultimate permanent disability rating itself, resulting from the use of the schedule, which is rebuttable. Thus, even if the component parts of the rating formula are not necessarily accurate (the individual impairments relating to body parts or regions, or the DFEC for that matter), if the permanent disability rating as a whole is reasonably accurate, there should be no basis for any type of rebuttal.

One of the problems with Almaraz/Guzman (and Ogilvie, for that matter, as will be seen) is that an injury under the AMA Guides can be broken up into multiple parts, each one of which is subject to separate impairment. If the narrow focus is only on the individual impairment itself, multiple rebuttals with respect to those component parts very likely result in large and unwarranted permanent disability ratings for relatively minor injuries.

With that in mind, we can look at some of the various methods, which are being proposed for rebuttal in connection with the AMA Guides. The Guzman approach used by Dr. Feinberg is to rate function, which is somewhat similar to the "analogy" method. In other words, if a total impairment with respect to a particular body region is a certain number, then the extent to which the function in that body region has been impaired can be converted to a percentage of that number. That is one approach, but sometimes the impairment itself does not necessarily relate to function, since impairment, as used in the AMA Guides, does not necessarily reflect the actual disability resulting from an injury. That is why a person who is in need of a back surgery, but does not obtain it, usually gets a lower impairment rating than one who has had the back surgery, with an excellent result. A prime example of this is the unpublished decision in Leprino Foods v. WCAB (Barela), 38 C.W.C.R. 83 (2010), which, while involving a somewhat different issue, is illustrative of this problem. Before the surgery, applicant had a WPI of 8% under the Guides; after his surgery, which everyone admitted produced an excellent result, the WPI was 23%. Go figure.

Utilizing the "analogy" method, the suggestion with, for example, back injuries is that, rather than using Chapter 16 (the back injury section, which is essentially anatomically based), use Chapter 4 (which is functionally based) instead. Other suggestions relate to adding disabilities (rather than combining them under the Combined Disability Table) where appropriate; the combining of otherwise exclusive impairments (for example, utilizing strength-type measurements even when there is pain and in addition to range of motion). Applicants' attorneys speak about the "synergistic effect", that is, a situation where a disability tends to compound the effect of another disability, which would warrant addition, or even multiplication, rather than combining, which has a compressing effect.

Headaches, which are strictly ratable only under Chapter 18 (relating to pain) might be rated under Chapter 13 (impairment of consciousness, mental status or dementia), and we have seen neurologists do this in post-traumatic head syndrome cases. Fibromyalgia could be rated under sleep and arousal disorders (although we suppose that an analogy can also be drawn to the complex regional pain syndrome tables).

Certainly, all of these are possible scenarios under Almaraz/Guzman, although, in every case, the physician needs to explain, first, why the strict approach to the AMA Guides does not represent an accurate reflection of an applicant's disability and, second, why the alternative approach does. Furthermore, the focus should always be on applicant's disability as a whole, rather than a narrow focus on the component parts.

Psychiatric cases present special problems. The 2005 Permanent Disability Schedule does not utilize the AMA Guides for the purpose of rating psychiatric disability; rather, it uses a conversion table based upon the Global Assessment of Functioning scale (GAF), found on Axis V of the Multiaxial Assessment System in the Diagnostic and Statistical Manual of Mental Disorders. The GAF is a 100-point scale ranging from 1 (basically, helpless, and a danger to self and others), to 100 (perfect in every way). There are ten 10-point categories, which are graded based upon two sources of information, psychiatric symptoms (e.g., depression, sleep impairment, auditory or visual hallucinations, etc.), and social/leisure and occupational functioning. Scores are assigned with respect to both sources, and the final GAF rating always reflects the worst score. Thus, for example, a person can be functioning rather well, holding down a job and supporting a family, but might have certain psychiatric symptoms (for example, panic attacks) which could result in a rather high

psychiatric disability rating (as opposed to the 1997 schedule, which was based on work functions, and where such a similar individual would probably have a rather low rating).

So, we can see how use of the GAF results in artificially high psychiatric disability ratings where a person seems to be functioning adequately, applicants' attorneys complain that use of the GAF scale results in artificially low psychiatric disability ratings in cases where the psychiatric symptoms are extremely debilitating. For example, a GAF score rating between 31 and 50 converts to a whole person impairment ranging from 69% to 30%. Yet, traditionally, a person with a GAF of 50 or lower is deemed unable to engage in substantial gainful employment for Social Security purposes, and will be awarded Social Security Disability. In examining the various descriptions, a person with a GAF score of 41 to 50 is said to have serious symptoms, such as suicidal ideation, or serious impairment in functioning (i.e., inability to keep a job), and person between 31% and 40% has reality and communication impairments, and is generally unable to work. A perhaps legitimate question posed by the Applicants' Bar is why shouldn't GAF scores in this range result in near or total disability (although an equally legitimate question is why someone functioning well, but with the occasional panic attack, should merit a 29% WPI).

The Applicants' Bar feels that the use of the GAF conversion table is contrary to the mandate of Labor Code §4660(b) (requiring incorporation of the AMA Guides). There seems to be some agreement that the conversion table is not really evidence based, but rather appears to be some sort of consensus derived formulation based upon suggestions from certain employer groups (Costco apparently played a role here).

CAAA's claim that the conversion table is invalid as being contrary to the requirements of Labor Code §4660(b) would appear to be flawed, however. Section 4660(b)(1), references "physical injury and disfigurement", and says nothing about mental injury. Thus, it appears that evaluation of psychiatric injury is legitimately outside of the Guides.

That is not to say that the GAF conversion table cannot be rebutted; certainly it can. Both Almaraz/Guzman and Ogilvie stand for the proposition that the component parts of the Permanent Disability Schedule can be rebutted, and the GAF conversion table is certainly a component part.

Applicants' attorneys suggest that one method of rebuttal is reference to Chapter 14 (regarding mental disorders) of the AMA Guides (How's that for a turnaround? After all the screaming about the unfairness of the AMA Guides, they are now embracing it as an alternative).

Chapter 14 of the AMA Guides does have one table, Table 14-1 (Classes of Impairment Due to Mental and Behavioral Disorders), but it contains no impairment numbers. This was deliberate, as the Guides specifically state that there appears to be no data to show the reliability of impairment percentages in connection with psychiatric disability, and the Committee on Disability and Rehabilitation of the American Psychiatric Association advised the Guides' contributors against the use of percentages, and that the authors of the Guides agree with that advice (page 361). In the face of this recommendation, the Applicants' Bar has, nevertheless, suggested a scale for Table 14-1. The scale is based upon the extent of impairment within certain "spheres", such as motivation, the affects of medication, social functioning, concentration, and decompensation. Extreme impairments in any one of the spheres would make one totally disabled, while lesser impairments would be rated in connection with how many spheres were affected. A second suggestion relates to the application of the degree of impairments to certain categories, such as understanding and memory, sustained concentration and persistence, social interaction, and adaptation.

In connection with psychiatric impairment, there is certainly a suggestion to rate pain disorders by analogy to psychiatric impairment. The AMA Guides note that a somatoform pain disorder is preoccupation with pain in the absence of physical findings that adequately account for the pain and its intensity (page 366), and it is contended that where pain severely disrupts various aspects of daily life, rating pain under Chapter 18 (3% WPI maximum) is inadequate. Instead, the pain should be rated in the manner in which it impairs function (along the lines of Table 14-1, although the problem, again, is that the Association is putting numbers to a table where the authors of the Guides specifically advise against it). The problem to be addressed, obviously, is a situation such as that in Olejniczak v. Airport Chevron, Case No. ADJ240116 (May 3, 2010), a panel decision where, although it was acknowledged the applicant had chronic pain that substantially interfered with her ability to compete in the open labor market, the Board refused to consider this, since chronic pain was not a ratable factor under the 2005 rating schedule (a big problem in this case was that the applicant presented evidence that she was unable to compete in the open labor market, and the Board

specifically noted that an inability to participate in the open labor market is no longer a recognized factor in determining disability under the new schedule; it is diminished earning capacity).

One method of avoiding the schedule entirely is the use of Labor Code §4662, which remains the same as it did prior to SB 899. Labor Code §4662 specifies certain disabilities, which are conclusively presumed to be total (loss of both eyes or total sight; loss of both hands or the use; practically total paralysis; and an injury to the brain resulting in incurable imbecility or insanity). The catchall is the last sentence, indicating that "permanent total disability shall be determined in accordance with the fact". There is still some grumbling that psychiatric injury should fit under the "brain injury" categories, but the panelists could not get their psychological panelist, Joshua Kirz, Ph.D., to agree with them on that point. Dr. Kirz suggested he subscribed to the opinion that a brain injury resulted from some sort of "trauma", an opinion which is reflected in the case of Sherry v. Connelley's Fine Furniture, Case Nos. OAK 216926 and 207971 (June 27, 2008), where the Board held that a consequential psychiatric injury resulting from a neck injury was just that: A psychiatric injury, and not a brain injury.

At least with respect to the specific injuries enumerated in Labor Code §4662, apportionment is unavailable. This is based on the language in the statute, which specifies that the mere existence of the disability as the result of a specified injury presumes totally disability. This was a specific holding in Kaiser Foundation Hospitals v. WCAB (Dragomir-Tremoureux), 71 C.C.C. 538, where applicant lost total use of her hands as the result of a cumulative trauma injury, and the defendant was denied an apportionment to a prior Award in connection with a prior injury with respect to both hands.

The Association is suggesting attempting to equate qualification for Social Security Disability to total disability in workers' compensation. Obviously, employers will resist this. The criteria for Social Security Disability is actually different (inability to engage in significant gainful employment, as opposed to total loss of earning capacity), and Social Security Disability also takes into consideration the so-called environmental factors (language, education, etc.), which should not really play a role in connection with determining industrially caused disability.

A word about Le Boeuf v. WCAB, 48 C.C.C. 587 (1983). Even though Le Boeuf dealt with the effects of an injury precluding an applicant from competing in the open labor market, there is no reason to believe why the general principles espoused in Le Boeuf do not remain viable. That was

certainly the suggestion in County of Los Angeles v. WCAB (Le Cornu), 74 C.C.C. 643 (the criteria for total disability these days is total loss of earning capacity).

In the appellate cases we have seen, we have not yet seen a specific application of Le Boeuf to a new schedule case, so we are still dealing with assumptions. One of the most recent ones relates to County of Sacramento v. WCAB (Chimeri), 75 C.C.C. 159 (2010, writ denied), where an individual had a significant physical injury (a 1996 injury), developed a complex regional pain syndrome as a result, and then developed an addiction to powerful narcotics, which were taken specifically in connection with the pain syndrome. Although the physical injuries were apportionable to non-industrial causes, the pain medication became necessary as a result of the pain syndrome, which developed after applicant's industrial injury. As the result of his use of narcotics alone, applicant was found to be unemployable, and was given a 100% Award. It did not matter that applicant may have had other disabilities which were apportionable to non-industrial causes; as long as one of the conditions, which was wholly industrial, totally disabled him, he was entitled to the 100% Award, without apportionment.

As one of the judge panelists stated, in effect, you deal with a person who is more than 100% disabled. A person who has multiple conditions, disabling him in different and more severe ways, should not be treated the same as someone with a lesser degree of a realistic disability, even though both may technically be at 100%.

Finally, one last word on who actually calls the shots on the extent of permanent disability. It is not the doctor, nor is it the rater. It is the judge. In Blackledge v. Bank of America, 75 C.C.C. ____ (2010), the physician gave applicant a slightly higher rating than the AMA Guides technically allowed, and following the trial, the judge gave the DUE an instruction to rate the disability pursuant to the physician's report, and consider a 3% add-on for pain. The recommended rating came back at zero, with the rater later testifying that the AME's assessment under the AMA Guides was invalid. The judge awarded 10% anyway, and the defendant appealed (why, we might ask). Reconsideration was granted, and the matter remanded, allowing the judge to take Almaraz/Guzman and Ogilvie into consideration.

The point, however, is that the Board noted the participants had the following functions:

(a) The physician is to assess the applicant's whole person impairment, supported by substantial evidence;

(b) The judge is to frame instructions based upon substantial medical evidence (and in this regard, the preformatted EAMS rating instruction was found to be deficient);

(c) The rater is to issue a recommended rating based solely on what the judge requests, and is not to volunteer anything, unless specifically asked to do so;

(d) No matter what the rater says, the judge is not bound by the recommendation.

III.

REBUTTING THE PERMANENT DISABILITY SCHEDULE PART III: OGILVIE REVISITED

To a certain extent, Ogilvie's affect on a permanent disability rating is actually much more predictable then the application of Almaraz/Guzman. That was also one of its most frustrating aspects, in that Ogilvie could be predictably applied to virtually every case where applicant had not worked since injury, with the effect of adding 18% to each whole person impairment which might be applicable in the case (leading some perfectly ridiculously high ratings). Overshadowed by the calculation of the formula were muted concerns by the Board that the formula might be subject to abuse by those who were more interested in manipulating their permanent disability rating than returning to work. However, it was the opinion of the Applicant's Bar that application of the formula itself was sufficient to create the rebuttal: If use of the formula took the DFEC adjustment factor out of the range proposed by the Permanent Disability Rating Schedule, then the standard DFEC adjustment had been rebutted, and the new adjustment factor was to be used.

It is clear from the series of cases which have recently issued that that is not the Board's view. Although so far we are only dealing with panel decisions (which are of questionable precedential value), the fact that several different panels are reaching the same result suggested that this may eventually be the view of the Board as a whole. Based upon what we are seeing in these cases, even some of the CAAA panelists are conceding that true Ogilvie cases may actually be rare. They concede that Ogilvie stands for the proposition that just because there is evidence that the Permanent Disability Rating Schedule is not accurate, that does not mean that the prima facie evidence

presented by the Schedule under Labor Code §4660(c) has been overcome, and that the Workers' Compensation Judge must explain why the evidence submitted in rebuttal is more persuasive.

Turning to the panel decisions, in Shini v. Pacific Coast Auto Body and Truck, Case No. ADJ2079252 (January 25, 2010), the trial judge awarded permanent disability of 41% based upon a mechanical application of an Ogilvie formula. Applicant had testified he had not worked since his 2005 injury, that he could hardly walk, did not believe that he could work because of his symptoms, did not know what he could do for work, and was considering going to school, but he had not really looked into that yet. Although the evaluating physician found the applicant was unable to return to his usual work, he gave the applicant a 13% whole person impairment, characterizing his discomfort as frequent slight, occasionally increasing to moderate on heavy activities. The evaluating psychiatrist suggested the applicant was malingering. The mechanical Ogilvie analysis was based upon a 100% loss of earning capacity.

The Board held this was improper, as there was no evidence to the effect that applicant could not work at all, and while the Board did "not wish to minimize the severity of the applicant's injuries", the Board noted anyway that his injuries appeared not to be substantial (they noted that applicant's individualized DFEC adjustment was so divergent from the scheduled adjustment factor, that a detailed analysis as to why this was justified was imperative).

In Ochoa v. UPS, 38 C.W.C.R. 89 (2010), an applicant sustained several injuries in 2005 and 2007, the trial judge refused to enhance the rating by means of Ogilvie, rejecting applicant's testimony that co-employees had received a $3.00 an hour raise while he was disabled. The judge suggested his testimony with respect to the raise was not really the type of empirical evidence demanded for an Ogilvie analysis, suggested that the applicant's subjective complaints were somewhat at odds with the medical evidence, and he had some questions with respect to applicant's motivation, as he had not made any attempt to return to the labor market. The Award was affirmed.

In Cortez v. Fru-Con Construction Corporation, Case No. ADJ4299001 (March 8, 2010), based upon a mechanical application of the Ogilvie formula, applicant was awarded a 54% Award in connection with a bilateral knee disability, which would have taken a 13% rating based upon a strict application of the AMA Guides. Applicant had a vocational expert who calculated the Ogilvie formula, but his analysis was found to be flawed because a part of his analysis with respect to why applicant remained unemployed was because of cultural factors: Applicant was monolingual and

nearly illiterate and, in addition, applicant had a prior, very significant industrial injury to the back. In granting reconsideration, the Board found, especially in connection with the lost earning capacity caused by the prior back injury, this violated Labor Code §4664(a), which provides that the employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment.

It was also noted that, because of this prior back injury, applicant had almost no work history at all prior to his present employment, and that applicant had been on Social Security Disability during much of the time. The Board noted that all of these factors contradicted the vocational evaluator's assumptions that applicant supposedly would have had post-injury earnings comparable to a physically robust, literate construction worker.

In Noriega Garcia v. Patrick L. Hinrichsen, 38 C.W.C.R. – Case No. ADJ6721939, March 1, 2010, applicant received a 65% Award based upon a mechanical application of Ogilvie, in connection with a January 5, 2007 injury. It was specifically noted that applicant was permanent and stationary as of August 5, 2008, and had been on temporary disability up to that time.

Reconsideration was granted. It was noted that a judge has discretion regarding what evidence to rely upon in determining an applicant's post-injury earnings, as well as the earnings period upon which to base the calculation but that the suggested period was three years, based upon the period that RAND used. It was noted that if an employee's injury results in a long period of temporary disability, then it might be appropriate to use a longer period than three years, and where there is difficultly assessing the employee's actual earning capacity because of recurrent periods of temporary disability, it might be necessary to initially use the schedule DFEC adjustment factor, and later reopening to reassess earnings. The Board noted that, while applicant could not return to her previous employment, there was no evidence presented that she could not work at all, and used identical language relating to the desire not to minimize injuries, although it did anyway, as had been used in the prior Shinin decision (so we now seem to have six commissioners as between the two decisions who would subscribe to this same idea). The Board noted that even if the DFEC rebuttal evidence was legally substantial, the judge still had the discretion to determine that the evidence did not "overcome" the standard DFEC adjustment factor component of the schedule. Consistent with Ogilvie, the Board noted that the judge should include a discussion of the factors set forth in Argonaut v. IAC (Montana), 27 C.C.C. 130 (1962) in determining applicant's true earning capacity.

The Montana factors are essentially summarized as follows:

1. Ability to return to work and medical limitations;
2. The skill and education of the injured worker.
3. Employment opportunities for similarly situated workers.
4. Injured worker's motivation or lack of motivation to work;
5. General labor market conditions; and
6. Reasons for the injured worker's failure to return to work, including retirement, change of residence, etc.

In today's calculation, the medical limitations would obviously relate to applicant's ability to engage in activities of daily living, and while applicant's occupation might have some relevance in terms of his ability to perform that same type of work, we think the ability to return to work (as noted by the above cases) involves much more than simply the ability to return to one's usual and customary occupation.

The Noriega Garcia case specifically referenced the problem of malingering for the purpose of manipulating the earnings loss calculation, and this may play a role with respect to the appropriate period to be used in assessing earning capacity.

It appears the period to be utilized, whether three years, or some other sufficient period of time, is intended to be uncontaminated by temporary disability (at least in most instances, although we can foresee exceptions in cases of extremely serious injury). In Noriega Garcia, the defendant suggested utilizing applicant's temporary disability indemnity as earnings for the purpose of calculating diminished earning capacity, but the Board rejected this approach, essentially holding that these benefits were not the same as earnings. On the other hand, the Board suggested that periods of temporary disability created a problem in accurately assessing diminished future earning capacity, and suggested that applicant be given an interim rating based upon the standard DFEC adjustment factor until sufficient time had passed so that an accurate assessment of earning capacity could be made.

The CAAA panelists suggested that this is a viable alternative, basically giving an applicant an interim rating based upon the standard DFEC adjustment factor, and reserving jurisdiction on the

Ogilvie adjustment. That is all fine and good, but we would certainly never concede that the reservation of jurisdiction could extend beyond the five-year period for reopening set by Labor Code §5410. Except for the rare exception relating to insidious disease with extended latency periods, the Board cannot reserve its jurisdiction to amend Awards past five years. Nickelsberg v. WCAB, 56 C.C.C. 476 (1991). To reopen a case for the purpose of changing awarded permanent disability after five years would certainly be the altering of an Award, and prohibited after five years.

Another interesting observation is whether or not the Ogilvie adjustment can be effectively applied if there is non-industrial apportionment. This question is raised in the Cortez v. Fru-Con case, where it was found that the Ogilvie analysis was flawed because the loss of earning capacity was based, in part, on non-industrial, or pre-existing factors.

Quite frankly, in a true Ogilvie case, we do not see apportionment causing insurmountable problems. Apportionment would simply be applied to the overall rating, as would normally be the case.

We think the clear message, however, is that the Board certainly seems to be reluctant to accept a proposed 100% loss of earning capacity without very clear proof of significant medical limitations.

What is also clear, however, is that vocational experts appear to have gotten a brand new lease on life, since the evidentiary and proof issues are going to be extremely difficult without one.

IV.

COSTS AND SANCTIONS

It is rather appropriate to address this subject in connection with the various means of rebutting the Permanent Disability Schedule, especially by way of Ogilvie. Labor Code §5811(a), in part, provides that "in all proceedings under this division before the Appeals Board, costs as between the parties may be allowed by the Appeals Board." Johnson v. Workers' Compensation Appeals Board, 37 Cal. 3d 235 (1984) states that "as a general rule, the WCAB is authorized to award costs."

The issue of costs is going to become especially critical in light of Ogilvie. In Costa v. Hardy Diagnostic, 72 C.C.C. 1492 (2007), it was held that the cost of hiring a vocational evaluator was a reimbursable cost and, in essence, where the services of such an evaluator were deemed reasonable and necessary, the evaluator was essentially accorded the status of a medical-legal evaluator pursuant

to Labor Code §4621(a): "The employee shall be reimbursed for his or her medical-legal expenses reasonably, actually and necessarily incurred." Since then, the trend of the cases has essentially been that, if there is any reasonable basis for retaining the medical-legal evaluator, the defendant is responsible for the cost. We think it is probably clear that a vocational expert is capable of testifying on issues relating to diminished future earning capacity. See, Lopez v. State Compensation Insurance Fund, 36 C.W.C.R. 67 (2007), although a judge does have the discretion to order the testimony taken by way of deposition, rather than taking trial time. Sherron v. American Casualty Company, 36 C.W.C.R. 44 (2008). In fact, the Board has the discretion to award the cost of a vocational evaluator even if that evaluator's reports are deemed inadmissible (and, presumably, his testimony is unpersuasive), and applicant loses on the issue. Barr v. Workers' Compensation Appeals Board, 73 C.C.C. 763 (DCA, 2008).

In the face of this, a defendant now takes a significant risk in establishing a policy of refusing to pay for vocational experts in the absence of a Board order. We note an ominous trial court decision in Navarro v. Thousand Oaks Construction, where the State Compensation Insurance Fund essentially admitted to such a policy, characterizing the vocational evaluator as a lien claimant, and his billing as a lien. The trial judge took offense to this, holding that the billing was a legitimate medical-legal expense, noting that the Fund's actions essentially disregarded the Costa decision, and that its actions would put a "chill on injured workers attempting to prove DFEC cases." It felt the Fund's actions were in bad faith and sanctioned it $2,500.00.

The court acknowledged that contesting vocational evaluation costs on a "case by case basis" was probably not inherently evil, so this actually raises two issues, the first being, is the service reasonably necessary for proving a contested claim. Assuming an applicant can come up with some rational basis for having the study performed, we think there is going to be liability for the cost, although applicant's attorney's statement to the Board in Lopez v. State Compensation Insurance Fund, 36 C.W.C.R. 67 (2007) to the effect "that it was a general feeling of the Applicant's Bar that the adequacy of the 2005 schedule of ratings should be litigated whenever that schedule was to be applied" we think falls into the same category of conduct as State Compensation Insurance Fund's "policy" in Navarro. If that, in fact, is the reason advanced for reimbursement of a vocational evaluator's cost, then obviously it is going to be contested.

The second issue relates to the reasonableness of the cost. Most of the cases are involving fees in the $1,500.00 to $2,000.00 range. Navarro, on the other hand, involved a $3,460.00 bill, and this suggests that the evaluators are going to be pushing the envelope.

We suspect that as this area develops, defendants will get a feel for what a reasonable cost should be in a particular case. One basis for comparison may be what defendants pay their own experts.

Which brings us to interpreters. Many of our clients have contracts with interpreting agencies at which services are rendered for specified fees. There is a move afoot by applicant's attorneys to prevent defendants from using these interpreters in connection with certain events, primarily depositions. The attorneys are claiming that, because of confidentiality issues, they should have the right to select the interpreter during the course of a deposition, arguing that an applicant has every right to be concerned that confidences will not be protected by an interpreter who has a contractual relationship with a defendant. Primarily, this problem is only going to arise during the course of off-the-record conferences between an applicant and his attorney (when the parties are on the record, nothing is said in confidence), but it may well give rise to a situation wherein if a defendant insists upon using its own interpreter during the conduct of a deposition, it may be faced with the prospect of having two interpreters present, a second one selected by the applicant for the purpose of providing services when attorney conferences are needed.

Applicants' attorneys argue that, in such cases, the defendant should have no right to a negotiated discount, but should be responsible to pay fees set by either the Board or a regulation.

A recurring source of conflict relates to interpreting services during the course of medical treatment. There is nothing specific in either the statutes or regulations relating to medical treatment, although applicants' attorneys argue, and most judges tend to agree, that a physician and patient understanding each other is integral to an applicant's right to receive medical treatment, at least in connection with those types of medical treatment appointments which involve the dispensing of medical advice and recommendations (essentially, the follow-up medical appointments). There are some panel decisions on this subject (Valenzuela v. Orange Grove Service, Case No. ADJ4663282 (2008), holding that an interpreter was entitled to fees for services during medical treatment appointments with the primary treating physician.

We also know that there have been attempts to expand the Labor Code §5710 envelope, which traditionally involved paying fees to applicants' attorneys for their time in preparing and actually representing an applicant during the course of a defendant's deposition (as well as paying travel time, when the applicant's attorney had to travel to the deposition). New and different services are added to the billings (review of file, consultation with client after deposition, review of deposition transcript with client, preparation of the objection to the notice to produce which accompanied the notice of deposition, etc.), and we have not yet really seen any panel decisions with respect to these requests. Trial judges tend to rubber stamp the deposition fee request (it makes us wonder at times whether they even bother reading them), and the excess fees are generally negotiated in connection with an overall settlement of the case. We do note one case in the syllabus materials, Cryder v. Salinas Valley Memorial Hospital, Case No. ADJ936547 where applicant's attorney was allowed travel costs associated with the taking of depositions of medical experts. This, quite frankly, is pushing the envelope.

Referencing back to the Navarro case, State Compensation Insurance Fund's actions were found to be bad faith meriting sanctions pursuant to Labor Code §5813. Regulation 10561 implements this section and contains a rather extensive list of examples of what would be considered bad faith (failures to appear; tardiness at hearings; filings of documents without legal justification; failure to timely serve documents; failure to comply with the Board's rules or orders; making false statements, presenting arguments or maintaining defenses not warranted under law; being generally offensive).

Finally, a word with respect to penalties. Labor Code §5814 provides that the Board may, where benefits have been unreasonably delayed, order a discretionary penalty up to 25% of the amount delayed. Ramirez v. Drive Financial Services, 73 C.C.C. 1324 (en banc, 2008) sets forth the criteria to be considered in determining whether a penalty is appropriate and, if so, the amount (the amount delayed; length of the delay, whether delay was inadvertent and promptly corrected; whether there was a history of delay; whether there was a statutory, regulatory, or other requirement of payment within a certain time; whether the delay was due to the realities of business; whether there was institutional neglect; whether applicant contributed to the delay; and the effect of the delay).

All well and good, although applicants' attorneys feel that SB899 essentially stripped the penalty statutes of any teeth, with the discretionary nature of the penalty, and the $10,000.00 cap.

We are skeptical with respect to this claim, but it is certainly not true in connection with delays which are post-Award, and where Labor Code §5814.5 comes into play. This section allows an attorney's fee to an applicant's attorney where payment of compensation is delayed after an Award has issued (explaining why, in an expedited hearing context, most applicants' attorneys now insist upon the issuance of an Award for the contested medical treatment or temporary disability; actually, this could tend to work in defendant's favor as well because of limitations which may come into play as the result of the five-year reopening period pursuant to Labor Code §5410, but that is another story). Ramirez specifically makes note of this section, and advises that the attorneys' fees awardable are similar to the fees which would be awarded to an applicant's attorney for responding to an employer's frivolous petition for writ of review pursuant to Labor Code §5801. In connection with such an attorney fee request, it has been held that an applicant's attorney can discover the number of hours billed by a defense attorney in defense of the penalty request (generally, only in connection with a claim by the defense that the number of hours spent by an applicant's attorney were excessive). Rasmussen vs. Paula Insurance Company, 32 C.W.C.R. 164 (2004).

The point is that the attorneys' fees more often than not far outstrip the amount of the penalty (see, Rick's Body Shop v. WCAB, 66 C.C.C. 184 (2001), where applicant's attorney was awarded $15,000.00. Northern California judges are apparently awarding $400.00 an hour for fees being sought under this section).

Obviously, there is some incentive here not to unreasonably delay.

V.

CIVIL CASES; SUBROGATION AND CREDIT

For our purposes, the involvement of civil litigation generally (but not always) brings into play Labor Code §3850, et seq. relating to the employer's subrogation (reimbursement) rights, and rights to credit with respect to obligations for future benefits. Despite the panelists' assertions that the civil case is generally worth substantially more than the workers' compensation case, we have our doubts, at least in cases involving lesser disability (and, in terms of the so-called "MIST" cases [minimal impact, soft tissue], participants were counseled to avoid these types of cases, if possible).

The civil case will be encountered in several different contexts. Less frequent are the so-called "cumulative remedy" cases, those in which an applicant not only has a right of action against the

employer in workers' compensation, but also has a right of action against the employer civilly. These cases involve employment practices liability (discrimination, harassment, or other wrongful employment practices which are either against public policy, or for which there exists specific statutory authorization for suit); assault cases (either directly by the employer or with ratification by a co-employee, Labor Code §3601); punch press cases [Labor Code §4558]; uninsured employer cases, and dual capacity cases.

Where there is specific statutory authorization for the civil suit in the Labor Code, there is generally a corresponding statute relating to the employer's credit rights with respect to the civil recovery as far as the workers' compensation case is concerned, because even in the public policy cases, there is also a public policy against double recoveries. See, for example, Labor Code §3602 (assault).

The majority of civil cases are generally not against the employer, and are often referenced as "third party claims". In general, the theory is that a person should be responsible for his or her own wrong. Workers' compensation is no fault, so the employer provides compensation whether it is the employer's fault, the employee's fault, somebody else's fault, or nobody's fault at all. However, where it is somebody else's fault, then the law favors imposing responsibility on that person for the damages caused. Part of those damages are the payments which are required of the employer in connection with the employee's workers' compensation claim.

Most of the time, the civil claim is initiated by the employee, and the employer joins in, although the employer is perfectly capable of pursuing the action alone (Labor Code §3854). In fact, when the employer does pursue the action alone, it is not limited to recovery of its actual expenditures, or even its anticipated expenditures. The employer is entitled to recover all damages to which the employee would be entitled (thus, accomplishing not only satisfaction of its subrogation rights, but applying the excess to any obligation which might be owed in the future, so as to entitle it to a credit.

In connection with subrogation claims in the civil court (and, to an extent credit claims at the Workers' Compensation Appeals Board level), the most nagging issue is the claim of employer negligence. We find that applicants' attorneys persistently fail (or perhaps refuse) to understand what this means in connection with its affect on the applicant's claim (particularly in connection with the civil case which, as often as not, remains pending after the conclusion of the workers' compensation case). Many applicants'/plaintiffs' attorneys subscribe to the strategy suggested by panelist James

Butler, who writes that it is "the job of every attorney representing plaintiffs/applicants in injuries arising out of the workplace... to stealthily assemble evidence of employer fault and to put into play a plan of action aimed at defeating the employer's claim for reimbursement." Why? Is the employer/carrier morally undeserving of being reimbursed for its damages simply because of its status as an employer/carrier? The indiscriminate attitude expressed here is disturbing. Another panelist expressed dismay at the inconvenience and burden put upon the plaintiff/applicant when the third-party defendant purchases and takes an assignment of the workers' compensation lien, which it then uses as a weapon of credit against the plaintiff. Why does a defendant do that? Take a look at Mr. Butler's statement.

So much for the soapbox. At least as it relates to employer negligence, a plaintiff's attorney going out and establishing an employer's negligence is essentially performing the job of the third-party defendant (for which the third-party defendant is grateful) and is in reality accomplishing nothing for his own client (because the public policy against double recovery ensures that the third party defendant will not be responsible for that portion of the damage which was caused by the employer's negligence; in other words, the third-party defendant obtains a credit against an applicant's recovery, and does not even have to pay for the lien). In the meantime, bad blood has been established between the applicant and his employer, which is likely to bleed back into the workers' compensation case, assuming it is still pending.

Since workers' compensation benefits and personal injury damages are significantly different a proportional formula is used to determine the amount of the offset, which is required by an employer's negligence. The theory here is that no one, including an employer, should take advantage of their own wrong (Civil Code §3517). The seminal employer negligence case is Witt v. Jackson, 57 Cal. 2d 57 (1961), which, back in the days of contributory negligence, held that an employer was entitled to recover nothing if any negligence on the employer's part contributed to the injury (at that time, any negligence by the employee would bar the claim as well). That all or nothing approach was later softened by Li v. Yellow Cab, 13 Cal. 3d 804 (1975), which introduced the doctrine of comparative negligence. Both subrogation and credit claims involve essentially the same formula. Associated Construction and Engineering v. WCAB, 22 Cal. 3d 829 (1978).

Both involve calculating applicant's total tort damages, determining the percentage of employer negligence, then applying that percentage to the total tort damages, and coming up with a value

(Example: Total tort damages are $500,000.00; employer negligence is 10%; amount of damage attributable to employer negligence is $50,000.00). In the subrogation case, the $50,000.00 is subtracted from the employer's claim, and the employer is entitled to recover all of its expenditures in excess of $50,000.00 (and the third-party defendant, in a litigated context where the case proceeds to judgment, would be entitled to a credit for that amount). In the case of a third-party credit before the Workers' Compensation Appeals Board, the employer is not entitled to a credit until it has expended its threshold, which in this case would be $50,000.00. Once that has occurred, the employer may then assert a credit for the balance of applicant's net recovery against any further obligation.

Assuming you have a plaintiff/applicant's attorney with whom you can work, it is probably in both parties' best interest to reach an agreement with respect to how both the workers' compensation and third-party case will be handled. For either party to proceed (especially in the workers' compensation case) without attempting to reach some accommodation is likely to prove detrimental to both. It is naturally in the employer's interests to attempt to minimize damages in the workers' compensation case, but this will adversely affect the applicant's third-party case and, correspondingly, will almost certainly adversely affect the employer's subrogation chances, and future credit rights (by reason of minimizing the plaintiff's third-party recovery). The more reasonable panelists suggested agreeing upon doctors, and agreeing to limit the physicians in terms of what they discuss in their reports (particularly in connection with apportionment). Certainly, this is doable, but it depends on applicant's attorney's willingness to defer prosecuting the workers' compensation case (in other words, taking cheap advantage) while the medical reporting is in a state which is disadvantageous to the defendant (which it will certainly be if certain issues such as apportionment are sidestepped).

We think the ultimate goal of such a cooperative effort would be, in the end, a third party Compromise and Release (which necessarily involves concurrent resolution of the third-party case and the workers' compensation case). Everybody's happy, but the big question is whether we can trust each other to accomplish this.

We have our doubts when we hear the following:

1. An applicant should resort to his own medical insurance to cover industrial medical expenses so as to defeat the employer's credit claim. Basically, the employee uses his

medical insurance up to the amount of the employer's credit, submits bills establishing this, and the credit is wiped out. Unanswered is what happens when the medical carrier later files a lien after the case has been resolved.

2. File a loss of consortium claim, and pile as much of the recovery into the spouse's claim as possible, since the consortium claim is not subject to either subrogation or credit.

Some special rules to keep in mind:

1. Government Tort Claims. These are not too much different than ordinary personal injury claims, except for the process of getting them started. Pursuing a civil action against a governmental entity (a California governmental entity; federal claims have similar type requirements) involves the filing of a government claim with the entity pursuant to Government Code §910, et seq. within six months of the date of injury and, if that is denied (and almost all of them are), then filing the lawsuit in the appropriate court within six months. Claims are deemed denied if there is no action on them within 45 days of submission (although, if the governmental entity does not act on the claim, that actually extends the time to file the lawsuit up to two years from the date of injury pursuant to Government Code 946.6).

2. Medical and Dental Malpractice. There is generally no right to subrogation in such a case, although there are limited credit rights, but only in connection with increased disability directly caused by the malpractice.

3. Subcontractor/Contractor Problems. The general rule is that a person who hires an independent contractor is not generally liable to third parties for injuries caused by the contractor's negligence (and the rule is quite strict regarding an employee who is injured at work and thereafter seeks a civil recovery against the entity which hired his employer. See, Privette v. Superior Court, 5 Cal. 4th 689 (1993). The very limited exceptions available to an employee in this area generally arise in connection with so-called "non-delegable duties". Basically, if the duty arises in connection with the hirer's role as a property owner, as opposed to its existence only because of the work which is being done, it may be non-delegable, and the employee may be able to sue.

An example is Evard v. Southern California Edison, 153 Cal. App. 4th 137 (2007), where a subcontractor's employee fell from a billboard owned by the contractor, where the billboard's owner had breached the non-delegable duty of providing guardrails or a safety line on the billboard.

4. Firefighters Rule. This is basically an assumption of risk defense applied primarily to firefighters and police officers (although, occasionally, to private citizens), who are held to assume a certain risk of harm by engaging in certain types of work activities. Very much like the going and coming rule, this defense has been shot full of holes, but it does find occasional application.

5. Uninsured and Underinsured Motorists. Technically, these do not really fall within the definition of third-party cases (they are sometimes referred to as "first party cases"). There is no right of subrogation or credit in these cases, since the applicant's recovery is said to be the result of a private contract between the applicant and the uninsured or underinsured motorist carrier. In fact, Insurance Code §1150.2(h)(1) permits the uninsured or underinsured motorist insurer to claim a complete credit or offset for the amount of workers' compensation benefits received by the injured worker.

VI.

COLA ADJUSTMENTS, PART III

The dreaded Duncan v. WCAB (XYZZX) opinion has been vacated by the grant of a hearing by the California Supreme Court. Duncan involved an interpretation of Labor Code §4659(c), which provided, essentially, that, in connection with post-January 1, 2003 injuries, life pension or total permanent disability recipients would have their payments 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". Duncan's holding was that the adjustments were to be applied to the statutory rate as of January 1, 2004, and each year thereafter (as opposed to the alternate arguments of commencing the cost of living increases as of the January 1 following the date of injury, or the January 1 following the date of first payment of the life pension).

With the Duncan case now off the books, applicants' attorneys are considering options. One of the primary concerns, of course, relates to fee computation but, from a defense standpoint, we are really not in a position to recommend anything other than the most conservative option available.

We start with the idea, obviously, that Labor Code §4649(c) applies, and requires a COLA adjustment at some point in a life pension case. The safest and most conservative course of action for a defendant would appear to be reliance on Loya v. Arrowhead Brass Products, 2008 Cal. Wrk. Comp. PB Lexis 87, which stated that the most rational way to define the phrase "entitled to receive a life pension" in Section 4659(c) is that one is entitled to receive a life pension only when the first payment of the life pension is due, which can occur only after the original award of permanent disability is fully paid. Thus, the cost of living adjustments begin on the January 1st following the first payment of the life pension.

Applicants' attorneys seem to concede that this may be one of the best things they could hope for, since obtaining a fee while waiting for the ultimate decision appears to be a priority. The idea is to stipulate to a start date for the COLA adjustments, perhaps based upon Loya, reserving jurisdiction to adjust the start date at a later time, assuming Duncan is eventually affirmed. There seems to be some feeling that an effort to do this would not be barred by the five year limitation set forth in Labor Code §5410, arguing that the adjustment would be similar to enforcing an Award, or a related ancillary proceeding, which would not be subject to time limitations, citing Barnes v. WCAB, 23 Cal. 4th 679 (2000) and Nickelsberg v. WCAB, 54 Cal. 3d 288 (1991).

We certainly would not concede that. Changing the COLA start date would appear to involve much more than the mere enforcement of an Award; it would alter it, as it would certainly involve the imposition of additional financial liability on the defendant. Nor do we believe that the attempt to change a COLA start date would be something akin to correcting a clerical or mathematical error. If a COLA start date is set forth in an Award, either by Findings and Award, or Stipulation, that is not a mistake. If the five-year statute runs, we think that date is then cast in stone.

Which brings us to attorney fee commutations. There are actually two methods of doing this, explained in Martinez-Reyes v. Solamar Farms, Inc., Case No. ADJ4200406 (January 19, 2010). The two methods are referred to as the "uniformed reduction" and "uniformed increasing reduction" methods, with the latter method being preferred by applicants' attorneys and, apparently, most judges. From a defense standpoint, the uniformed reduction would be the most preferable but it is

unfavored because of the rather significant affect it has on applicant's initial Award payments. Basically, the uniformed reduction method calls for a uniform or constant weekly reduction of the permanent disability rate averaged over the life of the Award (in other words, the deduction from applicant's weekly payment for the commuted fee never changes). The uniformed increasing reduction method calls for an increasing weekly reduction of the permanent disability rate which is actually tied to the state annual weekly wage increases, so that the initial deductions are less, and proportionately become greater as applicant's weekly rate increases.

Theoretically, if applicant lives out at least his life expectancy, there should be no monetary difference to the carrier (in fact, if an applicant outlives his life expectancy, the latter method may actually work in defendant's favor assuming the deductions continue). Not to be cold or heartless, the problem from the carrier's standpoint occurs if an applicant dies well before the end of his life expectancy, because at that point, the defendant does not obtain the full benefit of its commutation reduction. (Applicants' attorneys, of course, will respond that we should not complain, since further liability for the Award has been terminated, although, technically, with the commutation, you have paid more than you should have).

There is going to be a push to apply the cost of living increases to death benefits. Section 4659(c) obviously does not apply to death benefits, but Labor Code §4702(b) provides that the death benefits shall be paid in installments "in the same manner and amounts as temporary total disability indemnity would have to be made to the employee, unless the Appeals Board otherwise orders", with the caveat that the payments shall be made at least at the rate of $224.00 a week. The argument is that, if these benefits are to be paid in the same manner and amount as temporary disability, then they should be subject to the COLA adjustment set forth in Labor Code §4453(a)(10).

So far, judges seem to assume that no cost of living adjustments are available in death cases (noting Judge Lauerman's Opinion on Decision in connection with the Findings and Award in Peckham v. Resolution Law Corp, Case No. ADJ6790437 (April 8, 2010).

Technically, as long as the amount of the death benefit remains finite, application of COLA to the weekly payments should not make much difference in terms of overall financial liability. The real problem occurs in the open ended cases, involving young minors, whose payments continue until age 18, or, more significantly, incompetent minors, whose payments would continue for life.

VII.

OTHER ISSUES

A. Medical Treatment and Spinal Surgeries

Cervantes v. El Aguila Food Products, 74 C.C.C. 1336 (2009) was an en banc decision interpreting the parties' responsibilities under Labor Code §4062(b), relating to spinal surgeries. Essentially, it held that if a defendant wishes to contest a treating physician's request for spinal surgery, it must undertake utilization review and, if the spinal surgery is decertified, it is the defendant's obligation to object pursuant to Labor Code §4062(b), and, utilizing the form approved by the administrative director, request a second opinion, all within ten days of the spinal surgery request. If the defendant failed to meet any of these requirements, it was required to authorize the spinal surgery. At the time of our last report, we noted there seemed to be disconnect here between one of the requirements set forth in Labor Code §4062(b), that being the statement that "if the employee is represented by an attorney, the parties shall seek agreement with the other party on a California licensed Board certified or Board eligible orthopedic surgeon or neurosurgeon to prepare a second opinion report resolving the disputed surgical recommendation", before resorting to the administrative director's second opinion process. Nobody seems to mention this provision at all, although it would certainly appear to have application in cases where a qualified Agreed Medical Examiner has already been selected by the parties.

The Cervantes holding and procedure has now been approved by the Court of Appeals in Elliott v. WCAB, 75 C.C.C. 81 (2010). Elliott found that the responsibility for resolving these medical disputes was on the employer, since the employer is more familiar with the statutory time limits, as well as the documentation which needs to be presented to the administrative director (applicants' attorneys appear to be pretty astute with respect to the time limits as well).

In any event, there are certain burdens on applicants' physicians. First, the physician cannot (as we have seen some do in the past) bury their surgical recommendation within an incomprehensible, handwritten PR-2 (or even at the end of a long narrative). The report must clearly be delineated as a surgical authorization request, and it must come from the primary treating physician.

These are fallback positions. We would certainly suggest that any treatment recommendation, in any report, be submitted to Utilization Review, whether or not it technically complies with the notice requirements. This way, we do not get into trouble.

We previously referenced Leprino Foods v. WCAB, 38 C.W.C.R. 83 (2010), a District Court of Appeal decision, which is unpublished and unciteable. We wonder why it was unpublished, other than perhaps the court did not want to set precedent, but this is a case where both an Agreed Medical Examiner and Utilization Review determined that a treating physician's recommendation for spinal surgery was ill advised. Applicant self-procured the spinal surgery anyway, and obtained an excellent result. Despite the excellent result, his permanent disability rating was about three times what it had been prior to the surgery, but the court advised that the only consequence of an applicant's refusal to comply with the spinal surgery requirements of Labor Code §4062(b) was that the defendant was not responsible for benefits (temporary disability and medical) directly related to the surgery. Defendant was responsible, however, for any increase in permanent disability.

The decision is probably unpublished because no one wanted to think about what would have happened had the surgery gone terribly wrong, and the applicant been totally disabled.

B. Discovery

Far and away the most important decision in this area from a defendant's standpoint is Mendoza v. Huntington Hospital, 75 C.C.C. ____ (en banc, 2010), which invalidated the hated Regulation 30(d)(3), which precluded a defendant from requesting a QME panel in a denied case. In our prior analysis of this rule, we questioned not only its fairness (applicants were perfectly free to request panels, and were certainly free to produce report after report from their self-procured physicians, all of which were admissible), but also its consistency with the statute it supposedly referenced, Labor Code §4060.

Mendoza held that Regulation 30(d)(3) was inconsistent with Labor Code §4060 and §4062.2, since neither statute contained a limitation with respect to the time during which a QME panel could be requested (except to reference that it was available at any time after a claim was filed), nor did either statute limit the right to such an evaluation to only the employee.

Discovery with respect to vocational experts is certainly likely to become more important. Applicants' attorneys take the position that, in a case where vocational experts are employed, the defense expert has no right to interview the applicant. The underlying basis for this position is a civil case, Browne v. Superior Court, 98 Cal. App. 3d 610 (1979), in which the Court of Appeal held that since the governing statute relating to medical discovery required only a physical examination by a physician, there was no statutory authority for evaluation of applicant by a non-physician vocational rehabilitation expert, despite defendant's contention it was unfair, as the plaintiff was using a vocational expert who had had the opportunity to examine the plaintiff. The court seemed to feel that defendant's access to all the documentation prepared by the plaintiff's expert, as well as being able to subject him to a deposition and cross-examination seemed to given them sufficient protection.

Workers' compensation rules relating to discovery are somewhat different, but a Workers' Compensation Judge, in connection with a petition for removal in the case of Dunbar v. Bevcon Construction, Case No. SJO 209118, who ruled in essentially the same manner as the Browne court, suggested that defendant might have a remedy by arguing that applicant's refusal to submit to the defense evaluation might provide a basis for urging application of negative evidentiary inferences for failure to provide information within applicant's control. This is similar to the provision in Regulation 10622, providing that where there is a willful suppression of a medical report, it shall be presumed that the findings, conclusions, and opinions contained in that medical report are adverse to the party who is under the obligation to produce it. This evidentiary sanction seems to work a lot better.

Finally, a disturbing case is Coito v. Superior Court, 75 C.C.C. 240 (2010), holding that written and recorded statements obtained by a defense attorney are not subject to the work product privilege but, in fact, are evidentiary in nature and are subject to discovery. The Coito court specifically disapproved a prior opinion in Nacht and Lewis v. Superior Court, 47 Cal. App. 4th 214

(1996), which held that the discovery of witness statements prepared by legal counsel were privileged.

As a practical matter, this could have a significant impact, as defense counsel frequently conducts witness interviews in preparation for trial. The summaries prepared in connection with those interviews might well be discoverable under this case (even though the interviews themselves are not recorded or transcribed).

C. Apportionment

The case of Minivielle v. County of Contra Costa, 38 C.W.C.R. 7 (2010) actually is not that significant on its face in terms of the proposition for which it stands, except for what is being read into it by several of the applicants' attorneys' panelists. Minivielle basically held that an Award in favor of applicant under an old schedule (in this case, the 1973 Permanent Disability Rating Schedule) did not overlap disability with respect to the same body part, which was ratable under the 2005 Permanent Disability Schedule, for the purposes of Labor Code §4664. That is a reasonable approach. There really was not any discussion of Labor Code §4663 apportionment, presumably because the defendant had not attempted to produce evidence with respect to this statute.

Several applicant attorney panelists are taking the position, however, that where there is a prior Award, the only method of obtaining apportionment is through Labor Code §4664, so if overlap cannot be proved (and it can almost never be proved if different permanent disability schedules are involved), then the defendant is not entitled to resort to Labor Code §4663. Quite frankly, we think that is just plain wrong. We think it is an easy matter to request a physician to estimate what portion or percentage of applicant's current disability is due to the prior injury (of course, the physician may take the position that none is, but at least that is a Labor Code §4663 determination).

D. CIGA

CIGA has been on a winning streak in connection with its appellate attempts to escape liability where there is even marginal involvement by another, solvent insurer, but they ran into a roadblock in Fireman's Fund Insurance Company v. WCAB (CIGA), 75 C.C.C. 1 (2010). In that case, involving three injuries (two specific injuries for which CIGA had responsibility, and a

cumulative trauma injury for which Fireman's Fund had complete responsibility as other insurance), Fireman's Fund and CIGA entered into a Stipulated Award by which it was agreed that each party was liable for 50% of the cost of the medical care, and that CIGA would administer the claim and seek contribution from Fireman's Fund. The Stipulation was approved at a time when no case had yet been decided addressing CIGA's liability in situations involving multiple successive injuries, so the law was uncertain, and this represented the parties' attempt to minimize their risks.

Subsequently, CIGA's liability was further clarified (or, more accurately, non-liability), as it was held that where there were successive injuries with shared liability for medical care, CIGA was not responsible for either administering or the cost of such care where there was another solvent carrier.

Armed with this, CIGA attempted to slide out from under the Stipulation, an attempt which the Court of Appeal rejected stating that Stipulations, such as the one before it, furthered the public policy of settling disputes and expediting trials, and that their use in workers' compensation cases should be encouraged. Since the parties had assessed the risks inherent in litigating their positions, and decided to resolve those risks by means of the Stipulation, they were stuck with it. It was noted that pursuant to Insurance Code §1063.2, CIGA had the same right as any other party to negotiate and compromise claims.

E. Labor Code §132(a)

Actually, the first reading of the facts in Gelson's Markets, Inc. v. WCAB (Fowler), 74 C.C.C. 1313 (2009) suggested that the employer was going to have great difficultly prevailing in the Labor Code §132(a) claim. In this case, applicant received a release to return to work from his treating doctor, but the employer questioned the employee's actual ability to return, and did not allow him to return. An Agreed Medical Examiner subsequently gave applicant the same release, and the employer still doubted applicant's ability, and did not return him to work. Finally, three days before the Labor Code §132(a) trial, applicant was returned to work.

The trial judge found discrimination under Labor Code §132(a), but defendants successfully sought review from the Court of Appeals, which ruled that the employee was required to establish a prima facie case of lost wages and benefits because of employer discrimination, and this required the

employee to present evidence of disparate treatment, i.e., that the employer treated the injured employee differently than other non-industrially injured employees, thus making them suffer a disadvantage not imposed on other employees. An example of disparate treatment was shown in Anderson v. WCAB, 149 Cal. App. 4th 1869 (2007), where it was shown that an industrially injured employee was required to use vacation time for medical appointments, while non-industrially injured employees were allowed to use sick time. Because applicant in this case had not shown that he was treated differently than other non-industrially injured employees, he loses.

F. Independent Contractors

Quite frankly, the most surprising thing about Lara v. WCAB, 75 C.C.C. 91 (2010), was the fact that a commissioner and a Court of Appeal justice dissented from the finding that the applicant in this case was actually an independent contractor. Applicant was a gardener, who worked on a temporary basis for many employees, and advertised his availability by standing on a street corner by a telephone. He had his own tools, and he was asked by the defendant employer to trim some foliage above a diner. He had done this for the diner on a prior occasion approximately a year before. While trimming the foliage, he fell, and filed an Application for Adjudication of Claim against the diner.

The trial judge, as well as the dissents tended to take an emotional view (we think), basically looking at the public policy of the law and its purpose in protecting unskilled workers. No question this individual was probably an unskilled worker, and that his day labor as a gardener probably was not a thriving business, but the primary issue here was control, and the only thing the employer did was enter into an agreement with the applicant to trim the foliage. Applicant completely controlled the manner in which this was done, the tools which were used, and had no subjective belief (at least at the time the work was performed) that he was an employee. Objectively, this might be cold, but the result seems clear.

G. Admissibility of Evidence

Quinn v. Macy's West, 38 C.W.C.R. 42 (2010) involved a defendant's attempt to obtain a rebuttal report from a physician consultant, Dr. Brigham, who was utilized to review and critique medical evaluations postulating permanent disability from treating and medical-legal physicians. Dr. Brigham was neither a treating physician, nor a qualified or Agreed Medical Examiner, had not examined the applicant, but was simply commenting on the validity of a QME's assessment of an

impairment under the AMA Guides (pursuant to the Guides' admonition that reasonably intelligent people should be able to reach the same conclusions based upon the objective findings set forth in a report, without actually having to examine the applicant). The judge felt this was tantamount to doctor shopping, and it was pointed out by the panel that only Agreed Medical Examiners, Qualified Medical Examiners and treating physicians are authorized to write reports which are admissible into evidence before the WCAB. Since Dr. Brigham fit within none of these categories, the report was not admissible.

H. Return to Work

The importance of the return to work notice required by Labor Code §4658(d)(3)(A) just cannot be emphasized enough. It is not enough that an employee return to work with the employer, or even that the employee not miss a day of work. If the return to work notice is not sent, the employer not only does not get the benefit of the 15% reduction in permanent disability payments (this being the holding in Boatman v. Town of Windsor, 38 C.W.C.R. 9 [2010]), but if the employer had more than 50 employees, it will almost certainly be responsible for the 15% increase in disability (Pena v. City of Santa Rosa, 37 C.W.C.R. 102 [2009]). Send the notice. That is all that counts.

I. Temporary Disability

Foster v. WCAB, 73 C.C.C. 466 (2008) held that when two injuries concurrently contribute to temporary disability, the injured worker is limited to only 104 weeks of temporary disability, as set forth in Labor Code §4656(c). In Rasura v. State Compensation Insurance Fund, 38 C.W.C.R. 44 (2010), the question arose regarding applicant's temporary disability entitlement in connection with two successive injuries to the same part of the body, a 2004 injury, which resulted in temporary disability following which applicant returned to work, and then a cumulative trauma ending in 2006, which resulted in additional temporary disability. Under these circumstances, the Board held that each injury caused separate periods of temporary disability, so applicant was entitled to 104 weeks with respect to each.

The defendant was apparently arguing that its payment of temporary disability with respect to the 2004 injury was the commencement with respect to the cumulative back injury, citing Hawkins v. State Compensation Insurance Fund, 72 C.C.C. 807 (en banc, 2007), but the confusion here was that

there were two separate injuries, each with separate temporary disability periods. The key to a Foster argument is that the temporary disability periods have to be concurrent.

Finally, we have Collinswood v. Wausau Insurance Company, 38 C.W.C.R. 10 (2010). We really thought that the amputation issue had been settled (amputations entitle applicants to extended disability under Labor Code §4656(c)(2). In this case, the Board panel equated the removal of a breast implant from an injured breast to an amputation, entitling the applicant to augmented permanent disability. Quite frankly, as a practical matter, we are not entirely convinced that the removal of a breast implant constitutes the removal of a limb, part of a limb, or other body appendage, as was defined in Cruz v. Mercedes Benz of San Francisco, 72 C.C.C. 1281 (2007) (although, certainly, the removal of a breast certainly would have constituted the amputation).

VIII.

CONCLUSION

It is anticipated that the Court of Appeal's decision in the Guzman case will issue sometime in September, 2010. We also suspect that the aggrieved party will seek Supreme Court review and the issue appears important enough that the Supreme Court's acceptance of the case would not surprise us.

We will have to see what the courts do with respect to the other cases referenced in the introduction. We do know that the Workers' Compensation Appeals Board is proceeding as if Almaraz/Guzman and Ogilvie are, and will remain, good law. Especially with respect to Ogilvie, the litigation of these cases is becoming increasingly complex, and expensive. While we believe that the true Ogilvie case is probably relatively rare, many applicants' attorneys continue to claim the benefit of an Ogilvie adjustment in many of their cases, and the more recent panel decisions have certainly suggested that the use of vocational experts is going to be necessary for the purpose of resolving these issues.

When applicants' attorneys first began using experts (prior to Ogilvie), our position was to essentially insist upon application of the Permanent Disability Rating Schedule. We felt that since the Schedule was presumptively correct, it was up to the expert to make an overwhelmingly strong showing that something different needed to be done, and, quite frankly, most of them could not do it. We think that is changing, and where an applicant obtains the services of an expert to perform an

Ogilvie analysis, we think that under many circumstances, a defendant is going to be forced to obtain a rebuttal. As a matter of fact, one the judge panelists recently advised that, in connection with his review of a Stipulation with Request for Award involving an unrepresented applicant, he ordered the defendant to retain a vocational expert for the purpose of performing an Ogilvie analysis.

Coupled with all of this is the upcoming gubernatorial election, and the suggestion by both candidates that they would like to change the system in dramatically different ways.

Maybe the system does involve a little chaos.

Until the next convention, we remain,

Very truly yours,

BENTHALE, McKIBBIN & McKNIGHT

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