BENTHALE, McKIBBIN & McKNIGHT

A Professional Law Corporation

EDWARD J. BENTHALE
MICHAEL K. McKIBBIN
E. H. McKNIGHT, JR.
ALAN L. GROSS
SONA JALTOROSSIAN
HAROLD Y. HATA
ANDREW K. BORG
MAILY DINH
JOSEPH G. HIRSCH
JESSICA J. SNYDER
RYAN D. SUTHERLAND
E. SUSIE WENDORFF
ROBERT A. MATA
Of Counsel: GERARD R. DAGONESE

1450 IOWA AVENUE, SUITE 210 • RIVERSIDE, CA 92507-0508 • (951) 300-2140 • FAX (951) 300-2130 • www.benthalelaw.com

THE DEFENSE PERSPECTIVE AND OBSERVATIONS OF THE CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION 2012 WINTER CONVENTION

LOS ANGELES
700 S. Flower St., #3380
Los Angeles, CA 90017-4113
(213) 427-7820

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

SACRAMENTO
4600 Northgate Blvd, #209
Sacramento, CA 95834-1103
(916) 564-8977

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

2012 WINTER CONVENTION OF THE CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION JANUARY 26 - JANUARY 29, 2012

TABLE OF CONTENTS

I.

INTRODUCTION

To our clients:

As has been our practice, we are pleased to present a report summarizing some of the more pertinent details and events gleaned from our attendance at the 2012 Winter Convention of the California Applicant's Attorneys Association, which took place January 26 – 29, 2012.

Since the last Convention, workers' compensation in California may have undergone its most significant change since at least the initial issuance of the en banc decisions in Almaraz/Guzman and Ogilvie. The District Court of Appeal has issued its decision in Ogilvie v. WCAB, 197 Cal. App. 4th 1262, 76 C.C.C. 624 (2011). The Supreme Court has denied a petition for writ with respect to this case, so it is final.

The en banc Ogilvie decisions, at least at the outset, certainly cause problems, but subsequent refinement by WCAB panels clarified that application of the Ogilvie formula was not simply plugging in a mathematical formula. The decision had been refined to the point that an Ogilvie analysis, as a practical matter, would probably be undertaken only in those rare cases where an applicant's attorney felt that there was a gross disparity between the scheduled rating (even, perhaps, as modified by Almaraz/Guzman) and applicant's actual ability to go back to work. This was ensured by the requirement that the so-called Montana factors (Argonaut Insurance Company v. IAC (Montana), 27 C.C.C. 130 (1962)) be taken into consideration in determining whether or not the Ogilvie formula warranted application, as opposed to the scheduled DFEC modifier.

The District Court of Appeal in Ogilvie held that the DFEC was rebuttable, but tossed out the WCAB formula, noting instead three alternative methods of rebutting the modifier (two of which would appear to be very esoteric, the application of which appears extremely difficult to understand, despite the best efforts of some panelists to assert that they do. Without a doubt, vocational experts are going to be necessary in any Ogilvie type case, and we note the recent comments of Workers' Compensation Judge Valerie Sauban in her decision in the case, Gonzalez v. William McCullock, case numbers ADJ1709868

and 3671153 (December 13, 2011): "The above described formula will also do away with having to apply the more subjective analysis of future earning capacity as was required in Montana".

Chaos reigns, or at least it will for a while.

We think the Ogilvie decision overshadowed other very significant cases and changes which occurred in the last six months (relating to the state average weekly wage increases to life pension benefits, and MPNs, for example), so while we will of course be touching upon the other subjects which were covered at this Convention, we are going to start with Ogilvie.

II.

REBUTTING THE SCHEDULE, AGAIN:

OGILVIE AND ATTEMPTS TO INCREASE PERMANENT DISABILITY UP TO TOTAL

Regarding the 2005 Permanent Disability Rating Schedule which became effective following the implementation of Senate Bill 899, all cases which have considered it have held and acknowledged that Labor Code §4660 provides that the schedule is "prima facie evidence" of an injured worker's permanent disability, and is rebuttably correct. Every case, beginning with Costa has also held that because the schedule is only prima facie evidence, it is also rebuttable. Almaraz/Guzman and Ogilvie stood for the proposition that not only was the schedule as a whole rebuttable, but that the schedule could also be rebutted by rebutting its component parts (in Almaraz/Guzman, the AMA impairment rating, and in Ogilvie, the DFEC modifier).

By way of brief review, Ogilvie involved a long-term bus driver who sustained industrial injury to her back and right knee, and never returned to work. The scheduled rating on her disability was 28%, but Ogilvie sought to rebut it and, based upon evidence provided by vocational experts, the trial judge awarded a 40% disability, and we were off to the races. The Court of Appeal noted SB899 dramatically changed California's workers' compensation system, including the changes to Labor Code §4660(a), to require that a permanent disability award give consideration to an injured employee's diminished future earning capacity, rather than ability to compete in the open labor market. However, the court noted the Supreme Court's statements in Brodie v. Workers' Compensation Appeals

Board, 40 Cal. 4th 1313 (2007), to the effect that a permanent disability is the irreversible residual of a work-related injury that causes impairment in earning capacity, impairment in the normal use of a member, or a handicap in the open labor market. It was apparently this statement which proved critical, as the DCA held that, in its view, there was no meaningful difference between the terms "diminished future earning capacity" and "ability to compete in the open labor market."

The court essentially rejected the WCAB approach to rebutting the DFEC, suggesting that the imposition of the Board's formula was beyond its jurisdictional authority (perhaps, in a word, improper rulemaking), and suggested three possible methods of rebuttal (not necessarily in this order):

1. Rebuttal is permitted when a party can show a factual error in the application of a formula, or preparation of the schedule. The cases cited in connection with this actually seem to involve the mistaken inclusion of a non-industrial impairment in the rating, rather than any rebuttal of the schedule when the proper criteria was used. The court stated that certain assumptions with respect to injuries were critical, and if any of the assumptions were incorrect, the estimated ratings could be biased.

2. Another basis for rebuttal is where the amalgamation of data used to arrive at a diminished future earning capacity adjustment may not capture the severity of all of the medical complications of an employee's work-related injury.

Comment: These are the two esoteric methods of rebuttal. At least several of the panelists commented that rebuttal method number 2 actually appears to involve an Almaraz/Guzman type of rebuttal (in other words, the AMA impairment does not accurately characterize applicant's actual impairment). To the extent that anyone understands what the Court of Appeal was actually talking about here, the suggestion is that both of these exceptions would involve a detailed analysis of the RAND study which forms the basis of the present DFEC adjustment, a process which could possibly prove to be extremely time consuming and expensive.

3. Rebuttal is possible by showing impairment of rehabilitation. In essence, this is LeBoeuf v. WCAB, 34 Cal. 3d 234 (1983). To a certain extent, even though a number of cases have commented that LeBoeuf has no direct application to the 2005 permanent

disability rating schedule (certainly not true anymore in light of the Ogilvie decision), LeBoeuf was felt to be instructive in providing an analogy to a situation where there would be a total loss of earning capacity.

The problem here is that the Court of Appeal characterizes this rebuttal method as showing that an applicant has been impaired in rehabilitation, and that is a benefit which simply does not exist anymore. It was suggested by at least one of the panelists that this method of rebuttal would have an application any time an employer was unable to provide an accommodation permitting an applicant to return to work, and it certainly refuels what had been a diminishing attack based upon an argument that the DFEC variant based upon the RAND study was pretty much speculative in any event. We note the trial court decision in Wen v. Gagmar's case number ADJ6702670 (November 2, 2011), in which the trial judge justified a rebuttal under Ogilvie by accepting an argument that the RAND study contained "flaws" regarding applicant's particular injury, which did not account for the severe nature of applicant's injuries. We are not sure how this differs from an Almaraz/Guzman analysis (or whether the trial judge would have considered an Almaraz/Guzman rebuttal to be appropriate in addition to the DFEC rebuttal, although the opinion discloses the defense was not helped by the fact that its own expert estimated a rebuttal permanent disability rating substantially in excess of the scheduled rating).

The cynical observation regarding Ogilvie is that the Court of Appeal really has given absolutely no guidance not only with respect to when an rebuttal is appropriate, but also with respect to the nuts and bolts of how the rebuttal is actually supposed to be accomplished, leaving these questions, instead, to be developed by the WCAB. One thing that everyone seems to agree upon, however, is that the role of the vocational expert has now become critical.

Referencing what is likely to become the most common approach to attempting to rebut the DFEC factor (essentially, utilizing LeBoeuf), the Ogilvie court stated that this exception was to be limited to cases where the employee's diminished future earnings are directly attributable to the work-related injury, and not due to non-industrial factors such as general economic conditions, illiteracy, proficiency in speaking English, or an employee's lack of education. This particular admonition appears to have been completely ignored in

Cordova v. State Compensation Insurance Fund, 39 C.W.C.R. 291 (2011), where an applicant was found to be 100% totally disabled based upon vocational factors, in the face of the fact that applicant could not speak or understand English. The Board rejected the defendant's contention that applicant's lack of transferable skills related to his inability to speak English, indicating that everyone comes to the labor market with some innate limitations, and the fact that he was monolingual Spanish did not contribute to this total lack of earning capacity. That, of course, is bunk. Realistically, an applicant's inability to speak English in what is essentially an English-speaking country impaired his earning capacity prior to his industrial injury, and certainly foreclosed certain segments of the labor market to him. As a practical matter, what happened in this case, is that that pre-existing impairment was added to his industrially created one, to artificially increase the disability. The true issue should have been, assuming the applicant was capable of speaking fluent English, what areas to the labor market were open to him. This question does not seem to have been addressed.

There is a legitimate policy reason, we think, for discouraging the consideration of so-called "cultural factors", as we think was done in Cordova. If an employer knows that employing a person with such cultural factors puts him/her at risk for greater disability in the event of an industrial injury (based upon the rationale set forth in Cordova), there is going to be a reluctance to hire such a person. The policy, we think, should be to encourage employers to hire persons with pre-existing impairments (whether cultural or physical), and to ensure such employers that those impairments will not be held against them in the event of a subsequent injury claim.

Another issue relates to the problems of undocumented workers. We know that an undocumented worker is not precluded from receiving workers' compensation benefits, including permanent disability benefits, in the event he is injured. See Ruiz v. WCAB, 70 C.C.C. 1399 (2005). But how does this affect earning capacity? Legally, there is no labor market for an undocumented worker; in reality, there is no earning capacity to impair. We are actually somewhat surprised at CAAA's support for the plaintiff in the case of Salas v. Sierra Chemical Company, 76 C.C.C. 768 (2011), which involved an injured workers' civil claim against an employer for failing to accommodate disability resulting from that injury. Despite a rather exhaustive analysis of this case in the materials, the bottom line is that

Salas was an undocumented worker who was working illegally. Thus, the philosophical fluff relating to "unclean hands", where applicant had misrepresented his employment status, or whether a boatload of undocumented workers retained employment with the employer despite the fact they would not rehire applicant, is all irrelevant and unnecessary. The bottom line in this case is that hiring an undocumented worker (whether with or without an accommodation) is an illegal act and, in Salas, the court is being asked to not only sanction, but compel, an illegal act. We understand the Supreme Court is considering this case for a hearing; the issue would appear to be so elementary we are surprised it got this far.

There is an additional issue to rating an Ogilvie case, and that relates to how to determine the rating itself. For a time, CAAA appeared to endorse the dissenting opinion of Commissioner Caplane in Ogilvie, who felt that once the DFEC variant had been rebutted, the permanent disability rating was the percentage loss of future earning capacity (in other words, a rating string would no longer be necessary). However, in Gonzalez v. McCullock, case numbers ADJ1709868 and 3671153 (December 13, 2011), the trial judge felt this was not enough, feeling that the earning capacity loss percentage would only replace the WPI and DFEC variant (which suggests, interestingly, that Almaraz/Guzman and Ogilvie are mutually exclusive), and that this percentage would then be rated for age and occupation.

Attempts to rebut the schedule are also going to be found in connection with the combination of disabilities. In connection with the 2005 permanent disability schedule, where there are impairments/disabilities involving multiple parts of the bodies, the combined values chart found in the AMA Guides is used, the purpose of the chart being to ensure that regardless of the number of impairments, the summary value would never exceed 100% of the whole person (Section 1.4, AMA Guides). The combined values chart has a "compressive effect", in that the sum of the disabilities is reduced by the use of the chart (it is similar to the old multiple disability table, although the use of that table would not have as great a compressive effect). In fact, with respect to certain injuries, the old multiple disability table took "synergy" (impairments, when combined, produce a total effect that is greater than the sum of the individual impairment, based upon the dictionary definition), into consideration (e.g., loss of one eye was 25%, both eyes was 100%; loss of

grip in one hand was 36% or 40%, bilateral grip loss was 85%; the mobility of one hip was 45%, both hips was 100%). The new combined value chart does not do this.

CAAA argues that compressing disabilities is wrong. They argue that the AMA Guides do not mandate use of the combined values chart, but simply suggest its use in the ordinary case. There is some merit to this argument, as the guides (Chapter 1.4) does state that a scientific formula has not been established to indicate the best way of combining impairments, and concedes that a combination of some impairments could decrease overall functioning more than just adding the impairments together. Certainly, where those situations are established, it would probably suggest a ground for rebuttal pursuant to Almaraz/Guzman (because the combined value chart is suggested by the Guides, we would take the position that the results when using the chart are rebuttably correct). If a rebuttal is appropriate, the physician needs to explain the hows and whys (there was a suggestion that a vocational expert could do this, but, quite frankly, we think the basic opinion with respect to any rebuttal [except, perhaps, for loss of earning capacity below 100%] must be based upon the opinion of a physician).

CAAA has referenced an Oklahoma Court of Appeals case, Norwood v. Lee Way Motor Freight, 646 P.2d 2 (1982) for the proposition that compressing ratings is not appropriate. That court questioned the logic of compressing disabilities, although exactly how the AMA Guides were applied in Oklahoma workers' compensation law back in 1982 is somewhat unclear. Perhaps more to the point as far as California is concerned is Mata v. WCAB, 76 C.C.C. 833 (2011, Writ Denied), which involved an attempt to establish than an applicant was 100% disabled (the scheduled rating was 81%). Based upon the evidence presented, the Board rejected the applicant's contention that he was 100% totally disabled, but agreed with the trial judge of something higher than the scheduled rating was warranted (90%), affirming the judge's reason for increasing the rating based upon a "range of the evidence". An interesting side note to this case is the court's observation that the vocational expert was unqualified to give medical opinions relating to the effect of applicant's psychiatric disability.

III.

MEDICAL TREATMENT ISSUES

From the defense standpoint, probably one of the most important cases of the year was Valdez v. Warehouse Demo Services, 76 C.C.C. 970 (en banc, 2011). Valdez examined the statutory scheme relating to an employer's medical treatment obligation, and the obligation of an employee to treat within a validly established medical provider network, and concluded that if the employer has a valid medical provider network, and applicant has been given adequate notice of it, then the applicant must select a primary treating physician from within the MPN, and the reporting of non-MPN physicians is inadmissible for any purpose. Thus, the trial judge in Valdez was wrong in basing a temporary disability award upon the reporting of a non-MPN physician.

There was a dissent, which expressed concern with respect to two statutes: Labor Code §4605, which permits an employee to provide, at his own expense, a consulting or attending physician, and Labor Code §5703(a) providing that the WCAB may accept as admissible evidence the reports of attending or examining physicians. We read Valdez as being consistent with these sections; simply because applicant has the right to choose an outside physician does not necessarily mean that that physician's reports are going to be admitted into evidence, and the broad authority of the WCAB to accept certain reports as evidence is restricted by the more specific statute relating to the reporting of MPN physicians.

This, of course, is not going to end the debate. What concerns an applicant's attorney primarily is what is going to happen with respect to denied body parts. The panelists are convinced that insurance carriers instruct MPN doctors not to even take a history of injury to any body part other than those specifically admitted. We do not buy this. But the issues relating to denied injuries are real ones. Simply because a treating doctor suggests that an applicant is claiming injury to a part of the body other than that specifically admitted (the most common is probably psychiatric injury) does not mean that a carrier is going to be admitting the injury. Applicants' attorneys see this as a method of regaining medical control, i.e., an applicant complains of an injury to a non-admitted body part, the employer refuses to authorize treatment with respect to it, so the employee leaves the

MPN to self-procure treatment. Quite frankly, this is a difficult issue, and the reporting of the non-MPN physician under these circumstances might well be admissible. As employers and carriers become better at managing their medical provider networks, and advising employees of the obligation to use them, this is likely to become the front line battle over medical control. Normally, what is going to happen is that a primary treating physician will remark that an applicant is complaining of injury to another body part. If it is within his expertise, that physician will render an opinion with respect to causation; if it is not, he would generally recommend a consultation. In the latter case, our suggestion is that the consultation should be allowed (so as to maintain medical control). Once a physician renders an opinion with respect to causation, then the medical legal provisions of Labor Code §4062 can be invoked, hopefully with defendant being able to maintain medical control in the interim.

Applicants' attorneys continue to despise Utilization Review. One of the judge panelists suggested that, even in light of Sandhagan, she believed an applicant had the option of challenging a Utilization Review decision either by reference to Labor Code §4062, or by expedited hearing. Willis v. Waste Management, 39 C.W.C.R. 263 (2011) tends to refute this. In this case, Utilization Review decertified a primary treating physician's request for authorization to perform a knee surgery with postoperative physical therapy, and applicant immediately filed for an expedited hearing. The trial judge ordered the treatment, and defendant sought removal. The trial judge's determination was vacated, with the panel holding that the injured worker was required to challenge the Utilization Review determination by way of Labor Code §4062 (agreed medical examiner, or panel QME).

A note, however, on Utilization Review. This is not a defense conspiracy. By statute, employers are required to establish Utilization Review processes (Labor Code §4610), and, for the most part, Utilization Reviews are based upon the medical treatment utilization schedule adopted by the administrative director (which, in turn, is largely based upon ACOEM). These guidelines are presumptively correct. In our practice, we still see very many Utilization Review decertifications which are, in part, based upon the Utilization Reviewer's inability (i.e., due to the primary treating physician's failure to respond) to conduct a peer review with the primary treating physician.

IV.

COLA

Another very important case from the standpoint of the defense is Baker v. WCAB, 76 C.C.C. 1277 (2011), which was the Supreme Court's decision with respect to the appropriate date upon which to apply state average weekly wage adjustments to life pension and total permanent disability benefits.

In this case, applicant sustained an industrial injury on January 2, 2004, and settled his claim by way of a 69-1/2% stipulated award. He then filed an Application with the Subsequent Injuries Benefits Trust Fund alleging that, as between his industrial injury and a pre-existing non-industrial impairment, he was 100% disabled. The Subsequent Injuries Benefits Trust Fund stipulated to this, but then the fireworks started with respect to the commencement date of the state average weekly wage adjustment pursuant to Labor Code §4659.

Three potential methods were before the court:

1. Commencement begins on the January 1 following the first date upon which the life pension becomes payable (in the case of a total disability award, this would be the January 1 following which applicant became permanent and stationary); and this was the position advocated by the defendant.

2. Commencement date for the adjustment begins on the January 1 following the date of injury. This was the position advocated by applicant (and, thus, in this case the commencement date would have been January 1, 2005).

3. The commencement date for the adjustment in all cases is measured from January 1, 2004, the date set forth in the statute. This was the position first advanced by CAAA, and accepted by the Court of Appeals.

The Supreme Court noted that the fundamental rule of statutory construction is to ascertain legislative intent, and that the court was free to reject a literal construction of the statute which is contrary to legislative intent apparent in the statute, or which would lead to absurd results. The court noted a number of absurd results which could result from the Court of Appeals opinion, not the least of which was that life pension rights were already

escalating for persons who might not have injuries for decades. It was felt the legislature's intent was clearly to index life pension payments for inflation after an applicant actually began receiving those payments, so the court felt the appropriate date for which the indexing to commence would be the January 1 following the commencement of payment (the original defense position).

Applicant's attorneys, of course, are deeply disappointed by this decision, and at least some of them are grasping at straws, which they believe they see in the court's modification of its opinion filed on October 19, 2011. That modification stated as follows: "Our discussion of total permanent disability benefits pertains only to those payable for injuries occurring before April 19, 2004. For later injuries, it may be that an injured worker would become entitled to total permanent disability payments, and corresponding COLA's, before the worker's medical condition is permanent and stationary."

The attorneys are attempting to read into this that the Baker decision applies only to injuries occurring before April 19, 2004, but that is not the effect of the modification. The modification recognizes the reality that temporary disability benefits for injuries after April 19, 2004, are limited to two years, either from the commencement of payment, or 104 compensable weeks (as of January 1, 2008), and that in such cases permanent disability benefits are to commence upon the termination of temporary disability, rather than the actual permanent and stationary date.

The self-interest portion of this subject relates, of course, to attorneys' fees, especially fees calculated on a 100% award. A standard 15% of the present day value of such an award can be enormous. Thus, in Hamill v. Martinez Unified School District, ADJ3332026 (August 6, 2010), the DEU calculated a 15% attorney's fee of $370,890.12 based upon the estimated present day value of a 100% permanent disability award of $2,472,682.00. Contrast this with Wilson v. SCIF, ADJ2290591 (2011) where the attorney was awarded $33,217.95 with respect to a 100% award.

The Board in connection with both of these cases suggested criteria which should be considered with respect to awarding attorneys' fees in complex cases (and we would suspect most 100% cases would be considered highly complex), but there seems to be an implication that a 15% fee on the present day value of a 100% award would probably be

excessive. While the Wilson panel indicated that the attorney's fee in a 100% case need not be limited to what the fee would have been on a 99-3/4% case, the Hamill panel suggested that the fee in a 100% case should not be grossly disproportionate to the attorney's fee in a 99-3/4% case of similar complexity.

What is interesting in these attorneys' fees cases has been the DEU's estimated average of 4.7% with respect to the SAWW increase. This average is apparently based on a 50-year period, and we would think that this is certainly not representative of the increase over the past few years (this was observed by the panel in Wilkinson v. Ontario Neon Company, case number ADJ110788 (2011)). Wilkinson observed that the COLA average is not a regulation, and so the percentage to be used is not mandatory. We would think that a more appropriate percentage would be based upon a 10- to 20-year average, in which the percentages are 2.7% to 3.4% (which actually suggests a percentage of about 3%).

V.

MEDICARE ISSUES

The subject of Medicare compliance continues to be a growing thorn in everyone's side, so it becomes the subject of continuing coverage. We all know the general rules: Medicare may not make payments for medical treatment when another party is primarily responsible, although Medicare may make conditional payments if a workers' compensation administrator denies or fails to make payment, or when the medical service is furnished by a source not authorized to provide that service. Where this occurs, the purpose of the Medicare secondary payment statute is to ensure that Medicare obtains reimbursement. See, generally, 42 U.S.C. §1395y(b) and 42 C.F.R. 411.21 – 411.37. In connection with secondary payments, Medicare has a reimbursement claim against all parties and their attorneys for "past medical" expenses, to the extent that those parties had possession/control over settlement proceeds. Unfortunately, CMS (the Medicare administrator) has no easy mechanism in place to obtain reimbursement, and the burden actually falls upon the parties to identify, contact Medicare, and negotiate resolution of conditional payments. Medicare has a potential double damages remedy against anyone in possession of funds from the settlement if its interests are ignored.

Medicare's basic procedural rights and remedies are described in 42 C.F.R. §411.46 and §411.47. Thus, the regulation provides that Medicare need not recognize a settlement if it appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work-related condition, although Medicare does differentiate between so-called commutations (admitted claims) and compromises (disputed liability claims), and §411.46 does indicate Medicare will continue to pay medical treatment expenses in the cases of a settlement of a disputed claim (realistically, a large settlement, even of a disputed claim, would probably make Medicare skeptical).

The basic method of attempting to protect Medicare's interests in connection with a lump sum settlement is by way of the Medicare Set Aside Allocation ("MSA"). This particular device had its genesis in a document known as the "Patel Memo" in the 1990s which contained a number of overreaching statements, which had the effect of convincing everyone in the workers' compensation community that MSAs were a necessary fact of life. The Medicare vendor on the panel was asked to cite the authority by which CMS could go after a carrier post settlement for post settlement secondary payments, and the vendor replied that there was nothing which prevents CMS from going after the carrier, and no one pressed the point further. Of course, there is nothing in either the statute or regulations which actually authorizes CMS to go after the carrier in such a case.

Interestingly, there does not really seem to be much litigation with respect to secondary payer issues. The only post settlement lawsuit appears to be U.S. vs. Stricker, 2010 U.S. Dist. LEXIS 106981(N.D. Ala., 2010). Here, Medicare asserted a claim against the medical defendants, their insurers, and all attorneys who received fees from a $300 million settlement not only for conditional payments made prior to the settlement, but for conditional payments made subsequent to the settlement agreement itself. With respect to the post settlement claim, the theory was that a portion of the settlement was to be paid in 10 annual periodic payments. So, technically, there was still a fund from which additional payments could be made during the duration of those payments.

The court ruled against Medicare based upon the statute of limitations, holding that the statute of limitations actually began running as of the date of the settlement (contrary to Medicare's claim that the statute was tolled during the period of time the ten periodic payments were being made). We do not want to read too much into this, but the suggestion certainly is that once the statute of limitations begins to run, there are no subsequent rights (i.e., the only rights Medicare has are those which accrued prior to the commencement of the statute of limitations, and, thus, prior to the effective date of the settlement. Curiously, the case did not mention what claims, if any, Medicare was making against the recipients of the settlement proceeds.)

All the other litigations regarding conditional payments appear to involve those which were made prior to the date of settlement: Hadden v. U.S., 661 F.3d 298 (2011); Bradley v. Sebelius, 621 F.3d 1130 (2010); Tomlinson v. Landers, 2009 U.S. Dist. LEXIS 38683 (M.D. Fla., 2009) (in this case, a settlement agreement was vacated because defendants insisted on making Medicare a co-payee on the settlement check, arguing they had exposure for liability for secondary payments if they did not do this).

Post settlement, Medicare's regulatory remedy is to apply the settlement proceeds to any liability Medicare may have for medical payments. 42 C.F.R. §411.47(a)(2) actually provides a method for determining the portion of a settlement which would be allocated to Medicare expenses but, as a practical matter, what Medicare says it will do, in the event its interests are not taken into consideration in connection with the settlement, is that it will apply the full amount of the settlement to Medicare qualified expenses. That is a bit draconian, but it clearly puts the burden on applicant to make sure Medicare is not ignored. MSAs are desirable from the applicant's standpoint, however, because the authorization requirements for treatment are not nearly so stringent with Medicare, and authorization is generally granted much more expeditiously.

Some general rules are that while CMS does not require that MSAs be indexed for inflation, it also does not permit an MSA to be discounted to present day value (in connection with the cost of medical care, CMS insists that the dollar for dollar value of projected care be included). CMS may also consider apportionment of liability, but generally only in the disputed liability cases and then usually only where there is a court

order (unlikely in a case of disputed liability; the very nature of the settlement suggests that settlement occurred before the court had a chance to rule on anything).

In this regard, all parties are cautioned about what is included in terms of the injury. Be specific: if the injury is a herniated disc at L4-L5, that is what the MSA should say, rather than "back" or "spine" in general, since the MSA amount would likely then include medical treatment for non-industrial degenerative disc disease and arthritis as well.

A matter of concern to CAAA is a request for attorneys' fees with respect to the MSA. As defendants, we evaluate the settlement value of a case for the purpose of a Compromise and Release in connection with the value of indemnity owed, and probable future medical treatment. Where it is required, a large chunk of that future medical is generally represented by the MSA. Applicant's attorneys, of course, would like to take a fee on the entire amount of the Compromise and Release. This, of course, creates problems where the MSA is very large in relation to the indemnity to be paid, or the carrier is simply settling out the future medical aspect of a stipulated award. In such a case, an attorney is tempted to request that his fee be deducted from the MSA. CMS, of course, does not permit this at all.

Despite this prohibition, there is at least one state court case (Hinsinger v. Showboat, 18 A.3d 229 (New Jersey, 2011), wherein the court permitted a deduction of a large attorney's fee from the Medicare Set Aside. Almost certainly, CMS will take the position that the state court had no jurisdiction to do this, and upon audit, would probably hold the settlement recipient to the full value of the MSA. The panelists at the Convention agreed this is a very real possibility. We do note Pratt v. Wells Fargo Bank, ADJ579864 (October 2010), which stated that the proper method for calculating a reasonable attorney's fee with respect to a Compromise and Release should not include the funds paid to set up and fund the MSA. This case may actually be fact specific, in that it related to a Compromise and Release of the future medical care awarded under a previous award but, as a practical matter, since the Compromise and Release includes a combination of indemnity and medical care (as well as reopening rights where applicable), the total attorney's fee is based, in part, upon the value of medical care.

The panelists suggested that applicant's attorneys extract an agreement from defendants pay to the attorney's fee on top of the MSA. Certainly, defendants are under no obligation to do this, and the fee would certainly be negotiable if they were to do it. Whether a defendant would be motivated in this direction depends upon how badly the defendant wants to settle the case.

VI.

DISCOVERY AND SOCIAL MEDIA

It seems the prevailing attitude among many people is that when they are participating in chat rooms and social media sites, they have some expectation of privacy. That is not really true (one commentator suggested that if you would not like to see your post published on the front page of the New York Times, then you should refrain from posting it online). Despite the fact that it has been around for a few years, discovery in connection with social media sites is relatively new.

What little case law there is tends to draw analogies to the law involving electronic communications (telephone, email), and electronic information storage. The written materials in connection with this topic primarily consisted of two excellent law review articles: Millner/Duhl, Social Networking and Workers' Compensation Law at the Crossroads, 31 Pace L. Rev. 1 (2011); and Strutin, Social Media and the Vanishing Points of Ethical and Constitutional Boundaries, 31 Pace L. Rev. 228 (2011).

Both authors tend to agree that there are no cases regarding social media in workers' compensation. However, it is recognized that a workers' compensation claimant can communicate feelings, information or photographs on a social networking site that certainly contradict a claim. Social networking information which is not publicly available can still be obtained through the formal discovery process (noting that discovery is liberal and broad), and that the information obtained may well be admissible in court depending upon its relevance, authenticity, whether it is hearsay, original or duplicate, or unfairly prejudicial. Where we have used it, we have generally obtained authentication from the author (i.e., the claimant), bringing it to the claimant's attention during a process such as a deposition, and have not yet had a situation where the material has been denied as authentic (although claimants will allege that certain activities depicted occurred prior to the

injury; while we can determine when an item was posted, it is quite another thing to determine when a photograph was taken).

Relevant legislation would appear to be the Stored Communications Act (18 U.S.C. §2701 – §2712), enacted in 2006. It applies to internet service providers, and generally prohibits disclosure of information, with certain exceptions. Primarily, the exception is consent, although it appears to be accepted that a valid subpoena would extract the information as well (it does not appear that the Act would actually have application in the situation where a user has no security blocks).

The starting point, of course, could be searching the applicants name on one of the search engines, following which a site may be identified. At this point, there are a number of ethical concerns:

1. Certainly, anything which is publicly available is publicly available. Print it out.

2. An applicant's attorney acknowledged the potential dilemma in advising their clients with respect to utilizing a social networking site subsequent to an injury. Quite frankly, if an attorney were to tell his client to delete the site, or certain items within it, which would be deemed detrimental to the case, that can certainly be deemed evidence tampering. There are also ethical concerns which arise in connection with interaction between an attorney and his staff, and his client with respect to those sites, in terms of information which might be divulged during such networking, which, from a defense standpoint, are perhaps not as sensitive.

3. Defense ethical considerations. To a large extent, investigating through a social network is analogous to surveillance. First and foremost, there is an ethical obligation to refrain from communicating with an adverse party who is represented by counsel. To refrain from the appearance of impropriety, we submit this includes social network communications, even if the security walls are not up.

One gets past the security walls, of course, by methods such as "friending." There is a school of thought that, so long as the attorney does not become involved, there might not be anything unethical in the carrier assigning an investigator to "false friend" an applicant to get past the security wall. Quite frankly, false friending involves a communication, even if there is not an outright misrepresentation in connection with the

attempt to friend, and since communication is still being made to a represented party, this is going to cause trouble. We do not recommend it. Quite frankly, it brings to mind the old "rope jobs" which were condemned (and in fact, were actionable as an invasion of privacy) as surveillance techniques (the technique got its name from the investigator who befriended a claimant, took her to Disneyland, then filmed her as he shook her on the rope suspension bridge on Tom Sawyer's Island. That resulted in a big damage award).

Traditional discovery is capable of unlocking the site, if that is what is desired. Albeit, this could be a very expensive and time-consuming process, and it is not generally what would be recommended as a practical matter in the routine case where all that is desired is a fishing expedition. We think there would have to be some articulable suspicion that an applicant has posted significant, adverse evidence before the expense would be worthwhile.

VII.

SUBROGATION AND OTHER CREDIT ISSUES

As was pointed out in the law review articles noted in the previous section, workers' compensation laws are no fault insurance systems designed to resolve industrial injury disputes efficiently. See 31 Pace L. Rev. 1 at page 1. Since the employer pays benefits without regard to fault, if someone other than the employer and employee is at fault in causing the injury, then Labor Code §3850, et seq. contain provisions for the purpose of reimbursing the employer and imposing liability on the party who has the moral obligation to pay. In a word, these involve the concepts of third-party subrogation and credit. In other words, why should an innocent employer have to pay significant sums to an injured employee when another, financially responsible person and/or entity has caused the injury and damage?

Unfortunately, there seem to be a number of applicants attorneys who are not really giving adequate thought to this concept. The idea is to maximize the amount of money an applicant/plaintiff can collect from everyone concerned, regardless of the Legislature's purpose in allocating fault through the subrogation/credit statutes.

Thus, a panelist suggests surreptitiously working with a plaintiff's attorney to develop evidence of employer negligence for the purpose of ambushing the employer at a

subsequent time to defeat subrogation and/or credit rights (even suggesting the filing of a serious and willful misconduct petition, apparently without regard to merit, for the purpose of bludgeoning an employer into submission on these issues). In connection with this, it was suggested by another panelist that the serious and willful misconduct petition could well have a very adverse effect on the plaintiff's case as well, since it alleges pretty much intentional conduct causing the harm.

There seems to be an impression that it is possible to obtain a double recovery for an injured employee if employer negligence can be established. We respectfully disagree, and that is certainly not the policy of the Legislature, which is reflected in Labor Code §3850 to the effect that while every effort is made to make the applicant whole, the double recovery is against public policy.

To this extent, with proportional liability in civil proceedings, someone is going to get a credit for fault which is not attributable to the employee: either the employer gets it, and recovers his expenditures from the amount of damages awarded to the plaintiff, or, if it is determined that the employer is negligent, then the proportion of damages attributable to that negligence is credited back to the third-party defendant. Either way, a plaintiff does not double recover the damages he has already received.

The seminal employer negligence case was Witt v. Jackson, 57 Cal. 2d 57 (1961), the all or nothing approach of which was later softened by the adoption of comparative negligence (Li v. Yellow Cab).

Assuming there is employer negligence, either the subrogation recovery and/or the credit for the third party recovery are reduced in pretty much the same manner. We will take the panelist's example: a $1 million verdict with the employer being 40% negligent. A threshold number is obtained by multiplying the percentage of employer negligence against the total value of the case (40% of $1 million), resulting in a threshold number of $400,000. In a subrogation context, the employer is not entitled to any subrogation recovery for workers' compensation expenditures under $400,000 (and, conversely, it is entitled to recover its expenditures over that amount). In a third party credit context, the workers' compensation carrier is not entitled to assert a credit until its expenditures have exceeded $400,000.

What a lot of applicants' attorneys do not realize is that, after the application of the proportional fault doctrine, applicant's $1 million is reduced to $600,000, since the third party defendant is not responsible for the result of the employer's negligence. In this way, there is no double recovery.

One method of attempting to defeat an employer's subrogation/credit claim is to allocate a large portion of any settlement to a loss of consortium claim (the collusion does not really exist where there is a judgment, since the jury makes the determination with respect to the loss of consortium damages). A defendant is entitled to allege collusion, and can have the Workers' Compensation Appeals Board reallocate the amount in a credit context. CAN Casualty v. WCAB, 34 C.W.C.R. 40 (2006).

There are exceptions to the rights of subrogation and credit, those relating primarily to malpractice claims, and uninsured and underinsured motorist claims.

VIII.

THE REST

Several significant cases which have come down in the last six months should also be noted before closing, and are as follows:

Messele v. Pitco Foods v. California Insurance Company, 76 C.C.C. 956 (2011), dealt with Labor Code §4062.2(d) (and this might also have application to the AME/QME process set forth in Labor Code §4060 and §4061 as well) relating to the ten-day period between the proposal for use of an AME, and the filing for a request for a QME panel. The Board held that the time period begins when one party makes a written proposal for an AME to the other party, but where Code of Civil Procedure 1014 applies; (additional time for mailed notices), the parties must wait a full 15 days from the date the written proposal was made before submitting a request for the panel. Subsequent modifications have established that prior panel requests are to remain undisturbed to the extent that no objections were made on this particular ground.

A somewhat interesting side bar relates to Labor Code §4062.2(c), which provides that within ten days of the assignment of the panel, "the parties shall confer and attempt to agree upon an agreed medical evaluator selected from the panel", and in the absence of an agreement by the tenth day, each party may then strike one name from the panel.

Some applicants' attorneys are suggesting that this invalidates the use of a panel doctor where there has been no attempt to confer and agree upon a member of the panel.

The practical problem here is that this reading of the statute suggests that a party cannot really make a strike until after ten days from assignment of a panel. A lot of attorneys will take the position that if a strike has not been made within ten days, the right to strike is forfeited.

We attempt to solve that problem by advising opposing counsel in our strike letter that we would either propose one of the doctors on the panel as an AME, or more often than not, that we cannot recommend agreement of any of the doctors as an AME. And then we make our strike. We think this probably solves the problem.

Popovich v. WCAB, 76 C.C.C. 1050 (2011), involved an applicant's request to reopen a hepatitis claim more than five years after the stipulated award. Applicant was diagnosed with the disease, it was deemed industrial, and the parties entered into a stipulation in 2002 that the condition was an insidious disease process which extends the jurisdiction of the Board beyond the statutory five years. It was stipulated that applicant had not yet suffered disability.

Applicant did not become disabled until 2009, and filed his petition to reopen. The Court of Appeal found that a reopening was proper under these circumstances. To an extent, this case might be fact specific, based upon the stipulation of the parties (although it is generally conceded that subject matter jurisdiction cannot be conferred by stipulation). However, the result can also be explained by the statutory definition of cumulative injury, i.e., the date of injury is defined as the date when the worker first suffers disability, and knows or should have know that the disability is industrial. In this case, while applicant knew in 2002 that he had contracted an infection, he was never disabled. As a practical matter, despite the stipulation, the date of injury in this case was not really until 2009, when disability commenced.

Motheral v. WCAB, 76 C.C.C. 720 (2011) involved a case where an applicant was provided with housing by the employer, from which a portion of his wage was deducted. Defendant's argument was that the value of the housing was the amount which was deducted from applicant's wages. The court found that this was not a reflection of the true value of the actual benefit (the actual value of the housing), and that the true value of the housing provided was actually the correct measure to be used in calculating applicant's wage.

Finally, we have State Compensation Insurance Fund v. WCAB (Dorsette), 76 C.C.C. 810 (2011), which was an attempt by an applicant to impose extended Wilkinson liability on two different employers. Quite frankly, we do not see what the complaint is here. Applicant had two distinct injuries, a specific injury to his neck with one employer on March 21, 2000, and then a cumulative trauma at a different employer through June 8, 2004 with respect to the same body part. It is noted that, even under the old Wilkinson case, the doctrine essentially required the multiple injuries to be with the same employer.

In any event, the agreed medical examiner suggested that the second injury was a "compensable consequence" of the first, indicating the applicant probably would not have suffered the cumulative trauma had it not been for the specific injury. Applicant's attorney grasped at the "compensable consequence" remark, but that really is not accurate. Of course the applicant was more susceptible to the second injury as a result of the first (just as he would have been more susceptible to a neck injury had an insidious disease process such as arthritis been at work in the neck). This is a true apportionment/Benson case, and since the doctor was able to attribute percentages of injury to each employer, apportionment was properly applied.

IX.

CONCLUSION

In the words of a colleague (he has made this remark from time to time over the years), things are going to get crazy. With respect to Ogilvie, applicant's attorneys seem to be torn between the idea that it is not a concept to be applied in every case (in other words, is it rare?), and the admonition that attorneys ought to try to make an Ogilvie case every time an employer fails to return employee to work following an injury (which would make

application of the doctrine fairly common). Someone asked one of the panelists whether there was anything in Ogilvie which was favorable to defendants, and after some period of thought, the reply was, "no". Quite frankly, we cannot think of any reason to disagree.

The only bright spot may be that an application of Ogilvie may well eliminate consideration of an Almaraz/Guzman modification. If the Gonzalez case is correct, the two concepts may actually be mutually exclusive (and this would appear to be the case even if the percentage loss of future earning capacity is deemed to be the actual rating).

The tradeoff for the defense was more certainty in connection with the use of MPNs as well a reasonable approach with respect to the application of COLA adjustments to the life pensions and total disability claims.

It has been an interesting six months. There is some suggestion that a new permanent disability rating schedule is in the works, but when this will make its appearance is unclear. The adoption of such a schedule could, of course, change everything.

We hope you found the booklet informative. If you have any questions or comments, we would be happy to hear them. If you would like our firm to make any presentations with respect to the subjects covered by this booklet, or other subjects, please advise and we will be happy to make such arrangements.

Until the next time, I am,

Very truly yours,

BENTHALE, McKIBBIN & McKNIGHT

By: MICHAEL K. McKIBBIN
For the Firm