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THE DEFENSE PERSPECTIVE AND OBSERVATIONS OF THE CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION 2014 WINTER CONVENTION

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2014 WINTER CONVENTION OF THE CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION JANUARY 23-26, 2014

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I.

INTRODUCTION

To Our Clients:

We did attend the California Applicants' Attorneys Association Semi-Annual Winter Convention which was held January 23-26, 2014. Emotionally, the convention was relatively sedate compared to past conventions. Although it was not openly embracing the dramatic changes made over the years by Senate Bills 899 and 863, there now appears to be somewhat general acceptance, with a focus on how to best deal with the laws that presently exist. These are applicant advocates, however, so grudging acceptance does not mean a rollover, and the primary idea behind the focus, as always, is maximizing benefits and money.

Several of the panels plugged an electronic publication called "Pearls of the AMA Guides," which is essentially something of a digest, the purpose of which is to search the AMA Guides for supplemental impairments to be added on to primary injuries. Thus, there were discussions of the consequences of diabetes, coronary artery disease, and the use of Chapter 13 for the purpose of evaluating behavioral disability [perhaps for the purpose of sidestepping Labor Code § 4660(c)]. The idea behind the "Pearls" is to examine the impairment definitions of the various chapters, and compare those to an applicant's symptomatology and/or physician's diagnosis. The real issue, of course, is industrial causation, coupled with the nagging

realization that the predictability which was the focus of the reforms beginning with Senate Bill 899 has probably been relegated to not too much more than lip service.

There was a somewhat interesting section on the employer's perspective, and it was noted that a significant portion of the cost savings to be realized by Senate Bill 863 was contingent upon the reduction of liens in the system. It turned out that the primary tool for doing this was the activation fee which was required of a lien claimant of record prior to the commencement of a lien conference (with an ultimate drop dead date of January 1, 2014). That, of course, is now in limbo by reason of the ongoing federal litigation which produced a preliminary injunction against the enforcement of the activation fee on the ground that it denied those lien claimants which were subject to it equal protection (the fee was not imposed against accepted health carriers, such as Kaiser; the reason, of course, is that lien claimants such as Kaiser were not the problem. Lien organizations presenting $50,000.00 to $100,000.00 in lien claims from anywhere between 10 and 15 different entities for what in essence was nothing more than a sprain/strain case were). The observation was made that the legitimacy of the case in chief can often be influenced by these astronomical, multiple sham liens, and hopefully that is true. Legitimately injured workers need to stay away from these people, whose interest is clearly not practice of the healing arts.

Even apart from liens, the system is backlogged. During the WCAB Commissioner's Section, Chairwoman Ronnie Caplane points out that the Commissioners are shorthanded (there are normally seven of them; there are now five, and Commissioner Moresi is retiring in a month or so, so that will bring them down to four), and the commissioners are looking at 300 to 325 reconsideration petitions a month. We were told that most of these reconsideration petitions are coming from lien claimants, and then defendants. Apparently, there is no hope for replacement commissioners in the very near future.

The three biggest concerns from applicant's attorney's standpoints relate to the use of MPNs, the new Utilization Review rules, and, of course, methods by which the schedule can be rebutted. Thus, we will start with these.

II.

MPNs

This particular subject always begins with the basic responsibility of the employer to provide medical treatment which is reasonably required to cure or relieve the injured worker from the effects of the industrial injury (Labor Code § 4600). The statute goes on to state that if the employer neglects or refuses to do so, the employee may self procure.

Beginning with Senate Bill 899, in an effort to stem spiraling medical costs, the legislature allowed employers to create medical provider networks (Labor Code § 4616, et. seq.) which, if validly organized, with notice appropriately given to the injured worker, would enable the employer to compel an injured employee to receive all authorized medical treatment relating to an injury within such an organization. The basic notice requirements relate to pre-injury notice by the employer, and then pretty much immediately post-injury, in connection with the arrangement for initial treatment within one working day after the submission of a claim, and the subsequent notification of the employee's right to choose any doctor he wishes within the MPN (Labor Code § 4616.3 and Regulation 9767.6).

There are still applicant attorneys who intensely distrust the MPN, and while grudgingly conceding at this point that escaping the MPN might not be as easy as once imagined, still are submitting game plans for an attempt to wrest medical control (more about this later).

The primary method of seeking to escape the MPN was by attacking the validity of the notice given by either the employer or the carrier. These attacks were based upon a widespread misunderstanding of the en banc decision in Knight v. United Parcel Service, 77 C.C.C. 1423 (2006) (the holding in which continues to be somewhat misunderstood), which many advocates contend stood for the proposition that strict compliance with all of the notice requirements of the Code was required before treatment in the MPN could be enforced. To a certain extent,

rather than deal with this contention, some carriers simply turned to the continuity of care statutes and regulations (Labor Code § 4616.2 and Regulation 9767.9), which allow transfer of ongoing care from a non-MPN provider into the MPN. The disadvantage here, of course, was that the transfers were subject to certain weaning periods depending upon the type of injury which is being treated.

More recently, the Board began to clarify Knight's true holding (Hernandez v. Aramark), pointing out what the case really said was that where an employer's failure to provide notice of the MPN to an injured employee resulted in a neglect or delay of treatment, then an employee was justified in free choicing out of the MPN. However, where a defect in notice did not result in such a delay or neglect, then the defective notice could not be used as an excuse to "break out" of the MPN. (Typically, this scenario arose where an employee had been treating within the MPN without incident, until becoming represented). This interpretation is now recognized by statute (part of Senate Bill 863), which provides that the employer's failure to provide notice should not provide a basis for the employee to treat outside the MPN unless it could be shown that the failure to provide notice resulted in a denial of medical care [Labor Code § 4616.3(b)].

That is not to say that there have not been some legitimate complaints from applicant's attorneys with respect to MPNs (identifying doctors, obtaining appointments, communications). Labor Code § 4616(a)(3) now provides that a physician included within an MPN must actually submit a written acknowledgment electing to be a member of the network, and the administrative director's approval of an MPN is now limited to four years, following which reapproval is required. Applicant's attorneys complain that MPN physicians are economically profiled, but that is actually specifically sanctioned by Labor Code § 4616.1 (under certain conditions). We do think defendants are going to have to pay attention to their MPNs, particularly with respect to physician availability and responsiveness to applicant's (and their attorneys). Complaints could be the cause of an investigation by the administrative director [Labor Code § 4616(b)(4)], although there is a conclusive presumption that the MPN was validly formed once the administrative director approves it [Labor Code § 4616.2(d)(3)].

Quite frankly, most MPNs contain a wide variety of physicians, many of which would be considered applicant oriented. At least going in, we have never understood why applicant's attorneys simply do not leave their clients within the MPN for treatment, at least until an irreconcilable conflict arises, since this would seem to be the most expeditious way of maintaining a constant flow of benefits and authorization for medical treatment. Edwin Haronian, M.D., authored a small paper for the convention wherein, while he cautioned that the type of power given to employers/carriers by the MPN could be corrupting, he acknowledges that the pre-MPN era was complicated by the lack of medical control and, at times, endless treatment, and that the MPN process has resulted in adherence to the medical treatment utilization schedule and consistency of treatment between providers (at least within the MPN). He also notes that MPNs have largely eliminated unauthorized surgical procedures and, to some degree unauthorized treatment. He notes that we must all accept the fact that regulations are needed for cost containment, consistency in medical treatment, and transparency from all the parties involved in the workers' compensation system.

That being said, however, there is still an undercurrent by a number of applicant's attorneys who believe that medical control should be wrested from the defendant at any opportunity. Even conceding that the applicant may initially be properly within the MPN, they suggest beginning with "doctor shopping" (their words, not ours) within the MPN as permitted by Regulation 9767.7 (the second and third opinions, followed by a request for Independent Medical Review). Dr. Haronian feels this is motivated by a fear that MPN physicians are so controlled by the carriers that they will minimize impairment evaluations, and, in effect, negate the effects of Almaraz/Guzman by reason of threats of MPN exclusion/elimination (applicant's attorneys also complain of MPN physician's refusal to consider any complaints by their clients other than those which are specifically admitted by the carrier).

If an applicant is going to break out of the MPN, the primary justification for this is going to be a denial of care. We are convinced that it is probably not sufficient for the defense to passively stand by in the face of complaints from applicants that something is amiss in connection with the treatment they are receiving while validly within the MPN. We think the case law suggests it is probably critical for a defendant to be proactive in ensuring that medical care from an MPN physician not be delayed (or neglected). This seems to be one of the biggest gripes from applicant's attorneys, who suggest creating a paper trail of complaints, to later be used as a justification for self procuring care. They argue (with some justification) that if they can establish a right to break out of the MPN and assume medical control, that the defendant forever loses the right to compel the applicant to return to the MPN [Labor Code § 4603.2(a)(2)].

We do think carriers need to be mindful of Regulation 9792.9.1(a)(3) which requires that a carrier must maintain telephone access (in addition to fax) for treatment authorization. A carrier policy of refusing to consider telephone requests for medical treatment authorization might well be considered a denial of care under this regulation.

Quite frankly, we also think that one of the most serious threats in maintaining control through the MPN relates to parts of the body disputes. Included in the seminar materials was a letter from a carrier addressed to an MPN physician specifically directing the physician not to add "non work related body parts or injuries to a workers' compensation claim." Viewed in isolation, this is probably good advice, but it is clear that this particular letter was written in response to a physician who apparently expressed an opinion that a body part other than that specifically admitted was also injured in the industrial accident, and/or that the initial injury had resulted in some sort of compensable consequence type injury. Do not direct a doctor to ignore non-admitted body parts. We may not like it, but there is a specific method of dealing with this (an objection, an invocation of the medical-legal process under Labor Code § 4062). Virtually any workers' compensation judge we know would deem this type of letter a denial of care.

III.

UTILIZATION REVIEW AND INDEPENDENT MEDICAL REVIEW

CAAA points out that the legislative intent of Senate Bill 863 was to provide for timely and medically sound determinations of disputes over appropriate medical treatment. In this regard, Independent Medical Review was statutorily authorized by Labor Code § 4610.5. Regulation 9785, the reporting duties of the primary treating physician, essentially provides that the primary treating physician is under an obligation to render opinions with respect to all medical issues necessary for the purpose of determining an injured worker's eligibility for compensation. Secondary physicians are required to report to the primary treating physician, who is responsible for obtaining all of the reports of these physicians, and incorporating and commenting on them all. Prior to the regulations adopted pursuant to Senate Bill 863, the proper method of requesting authorization for medical treatment was as set forth in Regulation 9792.6(o) (First Report of Work Injury or primary treating physicians' PR-2 or equivalent). These were the only two events which actually triggered a carrier's obligation to perform a utilization review.

Except for the possible applicability to liens, this regulation is now history and the triggering event for a utilization review is now the Request for Authorization for Medical Treatment (RFA) (Regulation 9792.9.1), and it does appear that this request can be submitted by any treating physician, primary or secondary.

Before going on, it is probably important to understand what types of utilization reviews would normally not be at issue in litigation. First, a utilization review, generally, is not required in connection with emergency medical care [Regulation 9792.9.1(e)(2)]. Secondly, we do not expect to see many litigated disputes in connection with "concurrent" review. In connection with concurrent review, medical care cannot be discontinued until a care plan has been agreed upon by the treating physician, but this type of review applies only during an inpatient hospitalization [See Regulation 9792.6.1(d)]. This is a very limited type of review.

Certainly, one concern with the utilization review and Independent Medical Review process is going to be the cost of administering it. Independent Medical Reviews are expensive, in the area of (and in some cases) exceeding the cost of a basic medical legal evaluation [for the calendar year 2014, $475 per review, and up. (Regulation 9792.10.8)]. Thus, there is some merit, we think, to applicant suggestions that perhaps a claims examiner perform the utilization review himself/herself in terms of approving medical care which appears to make sense (the employer's wish list panel suggests that a Utilization Review should be avoided if possible, and that claims examiners become familiar with MTUS, and become an active part of the utilization review process.) We think this type of deference should especially be considered if a carrier is dealing with a credible and reputable MPN physician.

As noted, utilization review begins with submission of the RFA. Timelines are critical, although if there is a liability (including parts of the body) dispute, Utilization Review would be deferred. However, the statutes do appear to require notification of deferral within the same timelines as required for normal Utilization Review [Regulation 9792.9.1(d)]. It is contemplated these liability disputes will be resolved either by way of medical-legal action pursuant to Labor Code § 4062 (body parts disputes) or 4060 (injury AOE/COE disputes).

As actually noted in previous papers, there is some misunderstanding with respect to the actual time requirements for a valid Utilization Review: it is five days, not 14. Labor Code § 4610(g)(1). The 14-day period only comes into play if the Utilization Reviewer has not been provided with sufficient information to make the decision within five days, and then the provider needs to be notified within that initial five-day period that additional information is required. (These are normal requests; expedited requests are subject to the 24-hour requirement).

Regulation 9792.6.1(p) now defines the "request for authorization" as a RFA "completed" by the treating physician (this requires the physician to completely fill in the form). The claims administrator has the discretion to accept any other form of a request for authorization (or an incomplete RFA).

With respect to deferrals, once liability is established, the Utilization Review timelines on the previously submitted request for authorization begin to run as of the date the defendant's liability becomes final (prospective review), or, if the treatment has already been provided, within 30 days of the resolution of the liability issue (retrospective review) [Regulation 9792.9.1(b)(2)]. While there is an issue with respect to whether a new RFA is actually required once the liability issue has been resolved, the applicant's attorneys are, naturally, arguing that the original RFA is sufficient.

With respect to reviewer qualifications, a non-physician reviewer is sufficient for the purpose of providing authorization, but if a medical authorization request is altered, modified, or denied, then the reviewer must be "competent to evaluate the specific clinical issues involved in the medical treatment services", and the services must be "within the reviewer's scope of practice" (in other words, a physician with an equivalent scope of practice and competence). Regulation 9792.7(b). The doctor must be identified on the Utilization Review.

Assuming the Utilization Review is not challenged, it remains effective for 12 months [Labor Code § 4610(g)(6)], meaning that the claims examiner is under no obligation to do anything with an identical treatment request from the same physician, unless there is a documented change in the facts material to the basis of the UR decision.

Technically, this 12-month period does not apply to a Utilization Review denial which was based upon the Utilization Reviewer not having sufficient information in order to make a decision (the denial which comes on the 14th day after the treating physician fails to respond to a request for additional information). Once the information is provided by the treating physician, the Utilization Review can again be conducted (although, theoretically, this Utilization Review would be based upon different and additional facts).

At this point, several different things can happen. Regulation 9792.10.1(d) provides a mechanism for an informal appeal process (essentially, a peer review) to an initial Utilization Review. There is some concern that the 30-day timeline allowed for this could cause an applicant to miss the 30-day deadline for filing a request for Independent Medical Review but, because this procedure is authorized by the regulations, we have to believe that the time for

Independent Medical Review would be tolled during the informal appeal process (or, put another way, the IMR would be with respect to the appeal decision).

Just as a note, however, we are wondering if a lot of the problems created by Utilization Review denials could be resolved by the treating physicians simply sitting down and speaking with the Utilization Reviewer (the peer review). It is only very rarely where we see a Utilization Review denial where the treating physician has picked up the phone and talked to the Utilization Reviewer when the Utilization Reviewer attempts to call. Almost always, the Utilization Review denial notes that the Utilization Reviewer attempted to contact the treating physician anywhere from one to three times to conduct a peer review, only to be completely ignored. In a trial decision, Dubon v. World Restoration, Santa Ana WCAB No. ADJ4274323 (Sept. 20, 2013), Judge Pamela Stone, in upholding the validity of the Utilization Review and deciding that IMR was the only remedy, specifically found it "regretful" that the treating physician failed to engage in peer review, and failed to return calls to the Utilization Reviewer.

We have found that, on those occasions, when the treating physician is proposing something that is not completely off the wall, and engages in the discussion with the Utilization Reviewer, an accommodation can generally be reached.

However, assuming the adverse Utilization Review, what's an aggrieved applicant to do next? One tact is to take the position that the Utilization Review is untimely or otherwise deficient. State Compensation Insurance Fund v. Worker's Compensation Appeals Board (Sandhagen), 73 C.C.C. 981 (2008) stands for the proposition that an untimely or deficient Utilization Review is invalid, and the treatment issue may be resolved by the Worker's Compensation Appeals Board (generally by way of expedited hearing). In fact, in connection with the regulations adopted with respect to Independent Medical Review, the WCAB takes the position that an untimely or procedurally deficient Utilization Review is not subject to Independent Medical Review, because Independent Medical Review cannot be initiated without a valid Utilization Review decision (more on this later). Thus, when dealing with an invalid Utilization Review, the only method of challenging it may well be by the expedited hearing process set forth in Labor Code § 5502(d). Corona v. Los Appos Christian Fellowship

Childcare, 2012 Cal. Work. Comp. P.D. LEXIS 459; Becerra v. Jack's Bindery, Inc., 2012 Cal. Work. Comp. P.D. LEXIS 451.

Especially when dealing with lien claimants (although there are also a fair number of applicants' attorneys who believe this as well), the argument is that if a valid Utilization Review was not conducted, or there was otherwise a failure to timely act upon an authorization request, the medical treatment at issue is automatically deemed authorized and the responsibility of the defendant. That, of course, is completely false.

Even Sandhagen specifically held that, "notwithstanding whatever an employer does or does not do, an injured employee must still prove that the sought treatment is medically reasonable and necessary. That means demonstrating that the treatment request is consistent with the uniform guidelines. . . or, alternatively, rebutting the application of the guidelines with a preponderance of scientific medical evidence." In the paper authored by a prominent Southern California applicant's firm (Sparagna & Sparagna) the attorney laments that more and more physicians "have no concept of what constitutes substantial medical evidence. . . .their meager reports consisting of a couple of lines routinely precipitates UR denials and, if by luck the UR denial is defective, their failure to constitute substantial medical evidence results in a blockade that still prevents our clients' access to medical care."

This is especially true with the usual and customary cast of characters and organizations involved in the "lien factories", whose virtually illegible scribbles on PR-2's are said to constitute a legitimate basis for thousands and thousands of dollars of medical treatment.

So, assuming everyone is faced with an invalid Utilization Review, Steven Feinberg, M.D., in a paper authored for the convention, states: "to justify additional or continued treatment you will have to clearly document how the initial similar treatment resulted in a positive outcome (less pain, increased ADLs, etc.) and why additional similar care will further result in a further benefit." CAAA recognizes in its practice tip no. 14 that if the treating physician does not provide proper documentation for the need for the requested treatment, it will be denied. In Sanchez v. LA Unified School District, 2013 Cal. Work. Comp. P.D. LEXIS 396, a lien claimant's astronomical claim for "medical foods" was disallowed, despite the lack

of Utilization Review. The Board noted that, even in the absence of a Utilization Review, treatment is not automatically approved, but that the injured worker or lien claimant must still sustain their burden of proving that the treatment requested was medically reasonable and necessary. The Board went on to note that the lien claimant "does not explain why the particular medical foods being prescribed were reasonably necessary to cure or relieve from the effects of applicant's particular injury at the particular time they were prescribed."

Since the last convention, CAAA has advocated alternative filings with respect to adverse Utilization Review decisions: a request for Independent Medical Review filed with the administrative director, as well as a DOR requesting expedited hearing, but we're not sure this actually works. It is clear that the WCAB has no jurisdiction if it is dealing with a valid Utilization Review (the only remedy is IMR). On the other hand, there could be no IMR without a valid Utilization Review. There is some thought by applicants' attorney that they can pursue both processes and, if the IMR decision is adverse (i.e., the adverse Utilization Review decision is upheld), they can still pursue the "invalid UR" argument before the WCAB. Quite frankly, we do not believe that an applicant's attorney can do this.

If aggrieved by a Utilization Review decision, an applicant (through his representative) may file a request for Independent Medical Review within 30 days of the Utilization Review decision. Labor Code § 4610.5(h). This application is filed with the administrative director. The administrative director reviews the application pursuant to Regulation 9792.10.3(a), considering timeliness, previous IMRs with respect to the same treatment, liability assertions other than medical necessity, employee's date of injury, and failure of the treating physician to respond to a request for information. The administrative director may also request additional appropriate information from the parties in order to make an appropriate determination as to whether IMR is appropriate [subsection (b)]. If the administrative director makes a decision that Independent Medical Review is therefore appropriate, Independent Medical Review is thereafter approved by way of a "Notice of Assignment" (Regulation 9292.10.4), and upon receipt of the Notice of Assignment, the timeline begins for the IMR process (and if this happens, we think applicant has effectively elected his remedy, and that the

expedited hearing is no longer appropriate, as will be shown below). Essentially, Maximus (the Independent Medical Reviewer's organization) has 30 days from the receipt of all necessary documentation to issue its determination (because of the timelines for submission of medical records, the actual time period from Notice of Assignment to the determination is going to be in the 45 to 50-day range. [See, generally, Regulation 9792.10.5]).

Regulations 9792.10.5 and 9792.10.6 relate to the submission of documentation. Technically, there is nothing that prevents an applicant from obtaining a supplemental report from the treating physician and submitting it, assuming it can be submitted within the timelines. In connection with multiple treatment requests from the same physician, Regulation 9792.10.6(g) provides those requests may be consolidated, with the IMR timeline running from the last filed application for IMR.

The IMR decision is deemed to be that of the administrative director, and is pretty much conclusively presumed to be correct [Labor Code § 4610.6(h)], with extremely limited rights of appeal.

So, how is all this going to work? Thirty thousand IMR requests were filed over a two-month period of time. That's scary, and one has to wonder whether this will hopelessly bog down the system. However, here is a thought: once the administrative director assigns the matter for Independent Medical Review, has not the administrative director made its determination (at least implied) that the Utilization Review is valid? After all, only "valid" Utilization Reviews can be the subject of an IMR. Technically, an applicant's attorney could request the administrative director to make a determination with respect to the validity of the Utilization Review. Under Regulation 9792.10.3(b), by simply submitting the IMR request, an applicant's attorney may be conceding (or at least be requesting an opinion on) validity, and by assigning the matter out for an Independent Medical Review, that may well be a finding by the administrative director that the Utilization Review is, in fact, valid. At that point, we feel any further intervention by the WCAB is improper.

We do understand that there is a segment in the applicant's attorney community which believes that the limitations on the rights of appeal with respect to IMRs are unconstitutional, that litigation with respect to this may be forthcoming in the future. It is interesting to note that this is not necessarily CAAA's position as an organization. CAAA Bulletin No. 10 indicates that CAAA's actual position "that the IMR process may be a promising dispute resolution process if all concerned fully comply with the legislative mandates."

IV.

VOCATIONAL EXPERTS AND REBUTTAL OF P.D.R.S.

Labor Code §4660(a), defining the criteria to be taken into consideration when determining permanent disability, has undergone a few changes (one criteria was the ability to compete in the open labor market prior to April 2004; with that criteria changed to consideration of an employee's diminished future earning capacity), but the big change happened as of January 1, 2013, when any reference to either the labor market or the diminished future earning capacity was eliminated from the statute, and the only criteria listed was nature of the physical injury, occupation, and age at the time of injury. There have been no changes to the criteria for permanent total disability as set forth in Labor Code §4662. In connection with partial disability, the permanent disability schedule is prima facie evidence of the percentage of permanent disability. Labor Code §4660(c) and applicants' attorneys like to point out that, because it is "prima facie", it is rebuttable; the defense likes to take the position that because it is "prima facie", it is presumptively correct.

By now, of course, we are all aware of the case of Ogilvie v. WCAB, 76 C.C.C. 624 (2011), which allowed rebuttal of the future earning capacity criteria set forth in the Code, and further took the position that the court discerned no essential difference between the terms "ability to compete in the open labor market" and "diminished future earning capacity" (essentially, a distinction without a difference).

Now that both terms have been eliminated from the statute, there is, of course, an issue whether Ogilvie has any relevance at all, since the criteria for determining availability of employment within the open labor market and/or the effect of an injury on an applicant's future earning capacity seems to have been eliminated. Even the Commissioners suggest this is an issue which is probably going to have to be addressed soon.

It seems to us that the legislature probably contemplates the use of vocational experts in ongoing workers' compensation proceedings (unless that contemplation simply relates to injuries which occurred on or before January 1, 2013). We do know that the regulations now recognize the impact of vocational experts, treating them very much like doctors and providing that vocational evidence is now to be submitted by way of report (rather than by ambush testimony revealed for the first time at an MSC). Rule 10606.5.

Applicants' attorneys (perhaps somewhat optimistically) suggest that with the elimination of the diminished future earning capacity provision of Labor Code §4660, vocational evaluations may actually be easier (arguing that the prior statute compelled analysis based upon a generic "similarly situated worker", without regard to the actual injured workers particular characteristics). It is pointed out that the Labor Code §139.32(a)(3)(A)(ii) refers to evaluations of future earning capacity resulting from occupational injury or illness, although it is not clear how this will be consistent with the new amendment to Labor Code §4660.

Justification is found in the common law definitions of permanent disability, it being pointed out that the actual statutes do not specifically define permanent disability (only reference it, or describe certain criteria which may be related to it). Brodie v. WCAB, 72 C.C.C. 565 (2007) described permanent disability as being the irreversible residual of a work-related injury which causes impairment in earning capacity, impairment in the normal use of a member or a handicap in the open labor market. Since permanent disability in the context of workers' compensation does specifically apply to an individual's ability to work (as opposed to an impairment as defined in the AMA Guides), this definition may still have some validity. Total disability has long been defined by Erreca v. West States Life Insurance Company, 19 Cal. 2d 388 (1942), as a situation when an individual is incapacitated from following any

substantial or remunerative occupation for which he is fitted or qualified mentally or physically, and by which he is able to earn a livelihood. Some applicants' attorneys like to speculate that if an individual is unable to return to the specific job they were doing at the time of their injury, perhaps they have a 100% work disability, but that is probably nonsense. Even in the cases where vocational evaluation is appropriate, it is recognized that a rebuttal based upon vocational evidence does not mean that a person is totally precluded from the labor market, and that a vocational assessment can still result in permanent disability less (perhaps even far less) than total (see Dahl v. Contra Costa County, 40 C.W.C.R. 117 (2012), which also holds that the percentage of diminished future earning capacity also becomes the new rating).

Applicant attorneys tell us that the red flag for a vocational evaluation appear to be those whose injury/disability disproportionally impact their ability to return to employment either similar in nature or money to that they were performing at the time of injury. Basically, these are individuals with relatively low scheduled ratings, but very high lost earnings. Thus, if an individual is able to return to his regular work, at regular pay, then it is conceded that he may not actually have work disability (as opposed to a physical impairment). In Gerton v. City of Pleasanton, Case No. ADJ 6993381 (Panel Decision, March 12, 2013) the Board rejected the theory that an applicant suffered vocational loss despite earning equivalent earnings in an alternative occupation working for a relative (the Trial Judge described this as "charity", and that applicant was working in a "sheltered occupation"). It appears to us that the Board is determined to look at reality, and the reality of this situation was that applicant was working a real job and earning real money. As an aside, the we note Frazier v. State of California, Case No. ADJ 8008017 (Panel Decision, October 28, 2013), where the Agreed Medical Examiner decided the strict application of the 5th Edition of the AMA Guides mandated by the Code resulted in too much impairment, so we went to the 6th Edition of the Guides, which worked a substantial reduction. The Board found that use of the 6th Edition was not appropriate, and remanded the matter but, as one of the Panelists remarked, what's good for the goose is good for the gander.

In any event, approaches which we are likely to see from vocational experts are evaluations of lifetime earning potential, and how that is impacted by the effect of an industrial injury. To a certain extent, consequential consequence type impairments precluded by Labor Code §4660(c) are said to be permissible in making vocational evaluations (use of psychiatric and sleep consequences in connection with the vocational evaluation itself), and perhaps using a total ADL approach. One of the Panelists suggests that this attempt to reference ADLs may start bringing the matter dangerously close to the use of the old work restrictions from the old schedule, the use of which is now prohibited. An interesting case is Garcia v. WCAB, 78 C.C.C. 991 (2013) which suggested that it is improper for a doctor to rely both upon the impact an injury has on an applicant's ability to engage in activities of daily living, and the impact on the applicant's ability to compete in the open labor market, finding that there is inconsistent overlap between these two principles, and also suggesting that the physician was fishing through the Guides for the purpose of obtaining a desired result.

A newly published decision by the Court of Appeals, City of Sacramento v. WCAB (December 26, 2013) does hold that rating by analogy is appropriate where other sections of the Guide do not accurately assess disability. In this case, applicant did have residual symptomatology with respect to an injury, but strict application of the Guides gave him no impairment. This, of course, is problematic, when it is clear that an individual has symptoms which can be disabling.

V.

QUALIFIED MEDICAL EXAMINERS/MEDICAL-LEGAL OPINIONS

We have saved our discussion for the recent Supreme Court case of Valdez v. Workers' Compensation Appeals Board, 78 C.C.C. 1209 (2013) for this section rather than the section on MPNs since, while the case dealt with an important MPN issue, it does not really affect the procedural mechanism with respect to how MPNs operate, or legitimate reasons an applicant may have for leaving one. The true importance of Valdez is actually in the medical-legal context, i.e., whether non-MPN reports are admissible in connection with awards of benefits

where the defendant has a legitimate right to insist that medical treatment be administered through its MPN. The en banc Workers' Compensation Appeals Board decided such reports were not admissible for any purpose but, unfortunately, that determination was vacated and reversed by both the Court of Appeal and the California Supreme Court. The California Supreme Court essentially held that the statute upon which Workers' Compensation Appeals Board relied (Labor Code §4616.6) is a treatment statute, and the admissibility of reports under that section is limited only to situations involving diagnosis and treatment within MPNs. The reports are otherwise admissible under Labor Code §4064(d) (party may obtain medical reporting at their own expense, and such reporting is conditionally admissible), and Labor Code §4605 (the consulting/attending physician's statute), specifically noting the limiting language the legislature adopted with respect to this statute (presumably, in recognition of Valdez), which certainly authorized admissibility.

That limiting language provided that consulting/attending physician reports could not be the sole basis of an award of compensation, but must be addressed by a Qualified Medical Examiner and/or authorized treating physician.

All fine and good. Coming into the convention, we all assume Valdez deals with the reports of unauthorized treating physicians outside of the MPN. Apparently, however, there are several applicant's attorneys who give this case a much broader stroke.

There is a segment which takes the position that Valdez, in reality, authorizes an applicant to obtain their own private QME (primarily for the purpose of rebutting a permanent disability evaluation by either the Panel QME, a primary treating physician, or perhaps even an Agreed Medical Examiner). We think this absolutely corrupts what the Supreme Court had in mind when it decided Valdez (an applicant is free to obtain medical treatment at his own expense, and the opinion of those self-procured medical treaters can be considered to a limited degree by the Board in making disability determinations). Some of the more reasonable applicant's attorneys actually took exception to his interpretation, suggesting that the medical-legal statutes (Labor Code §4060 through §4062.2) actually prohibit this, and suggesting the possibility of a defense equal protection argument (if an applicant can get a private QME, there

is no good reason the defendant cannot), with the result being an expensive free for all over doctors. An alternative approach was suggested by one of the Panelists, that is, that if Valdez actually does concern itself with QMEs (i.e., that is what the Supreme Court intended), perhaps that is the signal that the Supreme Court considers the entire presently existing statutory scheme with respect to Agreed Medical Examiners and Panel QMEs to be invalid.

We will see.

There are some new regulations effecting the selection of Panel QMEs. Although written objections no longer have to offer the use of an Agreed Medical Examiner, they do need to be somewhat more detailed. They need to identify the primary treating physician, the date of the primary treating physician's report that is the subject of the objection, and a description of the medical determination that requires a comprehensive medical-legal report resolved (or, alternatively, attach a request for examination to determine compensability under Labor Code §4060). Regulations §30. We wonder how this effects the ability to object to the opinion of a secondary physician (particularly, as it may relate to an objection with respect to other parts of the body). Secondary physicians may now request authorization to treat by directly submitting an RFA. Granted, the regulations provide that the primary treating physician is supposed to incorporate and comment upon the secondary physician's report within 20 days of receipt, but this rarely happens. We just have to wait and see how the Medical Unit reacts to objections to secondary treater's reports.

Obtaining additional Panels is going to be more difficult. Until recently, the Medical Unit was simply responding to Panel requests by the issuance of a Panel, and if there was an issue with respect to the Panel, it was expected that issue would be addressed by the WCAB. Thus, when multiple referrals were being made to multiple specialties, although we did not like it, we still had the ability to request a Panel with respect to each specialty selected by applicant once the report was received. No more.

Regulation §31.7 now requires a showing of good cause for an additional Panel, which is defined as either a written agreement between the parties, or an Order by a Workers' Compensation Judge (there are provisions relating to the issuance of additional Panels in connection with acupuncturist Panels [why an acupuncturist should be considered a QME, is a complete mystery], and in connection with unrepresented cases, which involve the Information and Assistance Officer). It appears we are going to be doing a lot more petitions for orders.

The unconstitutional language in Regulation §30, relating to post-90 day requests for AOE/COE Panels under Labor Code §4060 has been somewhat removed (see Regulation §30(d)(1), although a subsection still suggests that the request needs to be made within the 90 day period for accepting or rejecting a claim. Despite the fact that this suggestion in the regulation is wrong and probably unconstitutional, it is probably still in the defense's best interest to get the request out as quickly as possible. Panel members are encouraging members to file DORs with respect to injury AOE/COE as soon as they get their medical reports, with the idea being that the applicants will thus have the only medical reporting on industrial causation. Quite frankly, when a defendant is first served with a medical report in this regard, we do think due process should give the defendant the opportunity to object, and then with reasonable diligence, request a Panel.

An interesting rejection of doctor shopping is illustrated in California Institute of Technology v. WCAB (Bonzo), 75 C.C.C. 735 (2010), where applicant, while unrepresented, was evaluated by a PQME. She then became represented, free choiced a doctor, and began treating. Defendant objected, and obtained another Panel, securing a report from another QME. The Board held that this was improper, that the subsequently obtained QME report was inadmissible, and that applicant should have been returned to the prior QME.

VI.

ISSUES CREATED BY THE AFFORDABLE CARE ACT

Very generally, the Affordable Care Act (ACA), sometimes known as "Obama Care", is intended to broaden the availability of health insurance by mandating issuance of standardized health insurance policies which do not contain exclusions for preexisting conditions, allow children to stay on their parents' health policy until age 26, and eliminate lifetime limits on the costs of care. They are available to anyone except Medicare and Medi-Cal recipients, as those individuals are already deemed to be covered. There are certain incentives and subsidies for enrollment, and tax penalties (enforceable by the IRS, although the mechanism for this is not really set up) for non participation. The policies are designed to provide minimum essential coverage in the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including dental and vision care. The panelists note that home care is not covered, but then it was not really covered under Medicare either.

The point is whether ACA coverage can be used to expand settlement opportunities for workers' compensation cases. Medicare presents a problem: If an applicant is a Medicare recipient, a workers' compensation settlement must address Medicare's interests both as to past medical expenditures (secondary payments), as well as future medical care (generally, the MSA). The consensus of opinion is that the ACA is not going to affect these requirements if the applicant is Medicare eligible or a recipient at the time of settlement (any more than a private insurance plan would impact responsibility to take Medicare's interest into consideration).

We are advised that there is no language in the Affordable Care Act which excludes coverage where workers' compensation is available (workers' compensation was, perhaps, under the radar, since nationally, it only accounts for about 2% of overall health care costs).

Thus, the question is whether or not coverage by way of an ACA policy can be incorporated into a settlement as a part of the settlement (we would think this would more than likely be a structured type settlement).

At this time, no firm conclusions are really being reached, as the concept is so new. It is noted that there is a great deal of hostility toward the ACA in some sectors, and there have been several active efforts to repeal or modify it. However, if it stays in place, the consequences to the workers' compensation community are thought to be, perhaps, a healthier general population, and a desire on behalf of injured applicants to engage in risk transfer, i.e., switch control of medical care from what is perceived to be an unsympathetic workers' compensation system to a more accommodating health insurance carrier.

This is a work in progress. We suspect we will be hearing more about in the conventions to come.

VII.

THE REST

A. Apportionment

There are several recent cases on apportionment which are of interest. Referencing back to the section on vocational experts, Acme Steel v. WCAB, 78 C.C.C. 751 (2013) related to a vocational expert's testimony that an applicant was totally precluded from the labor market based upon certain impairments, including a total loss of hearing, and the judge's award based upon that opinion. This was despite the fact that applicant had almost a 40% bilateral hearing loss prior to his injury. The court held that, while the WCAB certainly had the discretion to rely upon the vocational expert that the applicant was totally disabled, it did not have the discretion to disregard the uncontested apportionment, since a disability determination must ensure that an employer compensate only for that portion of the disability that is attributable to the injury.

Related to this issue is Warner Bros. Studio v. Workers' Compensation Appeals Board, 78 C.C.C. 79 (2013), dealing with the "conclusive presumption" set forth in Labor Code § 4664(b) (disability established by prior award is conclusively presumed to be present). In this case, the prior award was 0%, even though the Agreed Medical Examiner initially found 50% apportionment of the disability of the prior injury. Too bad. The conclusive presumption applied, and since the prior award was 0%, so was the apportionment.

This brings us to a very strange case, that being Southern California Edison v. Workers' Compensation Appeals Board, 78 C.C.C. 825 (2013). In this case, it was apparently stipulated that applicant had two injuries, a specific injury to various body parts rated at 29%, followed by a cumulative trauma. The subsequent Agreed Medical Examiner did not believe that the specific injury occurred, and felt all disability was the result of the cumulative trauma, and on this basis the judge awarded a 100% disability award with respect to the cumulative trauma. That could not be done either, but this case was so strange and convoluted that it was ordered unpublished, probably for good reason.

From a defendant's standpoint, however, the really terrible cases with respect to apportionment relate to those where disability from the underlying industrial injury becomes pretty much irrelevant, and the real disability now relates to applicant's chronic addiction and use of pain medications. Where chronic pain truly exists that is, of course, a disease in of itself, and those of us who have not experienced it probably do not have an answer for it. The answer of most doctors is to simply feed the condition drugs and, eventually, the individual is as much a hopeless drug addict as the heroin addict or chronic alcoholic out on skid row.

Either way, the individual cannot function, and it is easy for a doctor to say that, independent from anything else, applicant is incapable of functioning because of his drug addiction. When that happens chances are we may have a 100% total disability case without apportionment. See County of Sacramento v. Workers' Compensation Appeals Board, 75 C.C.C. 159 (2010).

B. Attorney's Fees

The two attorney's fees cases are different, because they arise under Labor Code § 5801 (attorney's fees awarded in connection with what is perceived to be a frivolous filing of a Petition for Writ of Review by a defendant). The Commissioners tell us that it used to be that an applicant's attorney would be awarded a flat $2,500.00 by the workers' compensation judge in such cases. Those were the days. Services are now evaluated on a reasonable hourly basis, with the hourly rate apparently fluctuating on degree of difficulty (although where a Petition for Writ of Review was deemed pretty much frivolous, how difficult could it have been?). The two cases to which our attention was brought were Castaneda v. Pelis Ruelas, 2013 Cal. Wrk. P.D. Lexis 299 and Diveiros v. Pure Lock City Tow, 2013 Cal. Wrk. P.D. Lexis 343, both workers' compensation panel decisions. The hourly rates in each case were $300.00 and $400.00, respectively, and some suggestion that a certified specialist would be entitled to more than $300.00. There is a suggestion in at least one of the cases that the reasonable value of the hourly rate is not necessarily dependent on what the local divisions are paying as Labor Code § 5710 fees.

C. Res Judicata

We suppose State Farm General Insurance v. WCAB, 78 C.C.C. 758 (2013) stands for the proposition that, if you are aggrieved by some sort of order which potentially permanently affects your rights, you need to do something about it, even if you are CIGA. In this case, although there was no dispute with respect to the industrial injury, there was a dispute with respect to who actually employed applicant at the time of the injury, a dispute which was resolved by way of a stipulation between the carriers from the respect of employers, whereby Fremont agreed to administer and pay 75% of the benefits, and State Farm agreed to reimburse Fremont its 25% share. Fremont later became insolvent. CIGA began administering, and filed a Petition for Dismissal in 2003, to which State Farm objected, arguing the original stipulation was final and binding, and no action was taken. In 2008, CIGA sought to be relieved as

administrator, the matter proceeded to trial, and the judge determined the original stipulation was binding. CIGA did not seek reconsideration.

CIGA subsequently filed another Petition to be Relieved as Administrator, and then filed a DOR requesting dismissal, which was denied, and this time CIGA's Petition for Reconsideration was denied.

Following the trial of applicant's case in 2010 (one has to wonder what applicant was doing during this entire period of time), again the Board found that the original stipulation was valid. In 2011, CIGA again sought an adjudication of its liability and, although the judge found that the original stipulation was binding, this time the WCAB granted reconsideration, ruling that since CIGA was not a party to the original stipulation, it was not bound.

If at first you don't succeed . . . The Court of Appeals filled in the blank here by deciding that res judicata applied on several different levels, probably as far back as the first decision deciding CIGA was bound by the stipulation. Interestingly, we are not really sure that the court actually answered CIGA's primary issue: since it was not a party to the original stipulation (the underlying insurance carrier for which it was acting was the party), would CIGA be considered bound by the prior stipulation? That may be a question which will have to be answered in the future.

D. Jurisdiction

We do note recently enacted Labor Code § 3600.5, relating to injuries to out of state residents. Significant changes to this section relate to claims by professional athletes with little or no contact in this state other than the fact that they played a few passing games. The changes, which restrict nonresident athletes rights to bring cumulative trauma claims within this state, applies only prospectively to injuries occurring after its effective date.

The statute was enacted in response to the fact that California is the state of choice for every professional athlete in the country to be filing workers' compensation claims (it is one of a limited number of other jurisdictions which recognizes the concept of cumulative traumas, and the underlying belief is that the statute of limitations with respect to such claims is virtually

nonexistent). Perhaps at this point, however, even the courts are recognizing that enough is enough.

In Fed. Ins. Co. v. WCAB, 78 C.C.C. 1257 (2013) a nonresident professional basketball player who played with non-California teams, and played one professional game out of 34 in the state of California was found to not have sufficient contact with California to vest jurisdiction with the California Workers' Compensation Appeals Board. California's interest was held to be "de minimus," and because the State did not have a sufficient enough relationship with the employee's injury, the court found it would be a violation of the employer's due process to apply California law.

Quite frankly, we are not at all sure this is an actual jurisdiction case. Applicant did have a minimal contact with the State (one game), that might be enough for personal jurisdiction. The real question may actually relate to "choice of law." In other words, California's contact was so slight that the State had no vested interest in applying its law in connection with the adjudication of applicant's rights. That would best be left to the jurisdictions who have substantial contact with the applicant and her employer.

E. Miscellaneous

Finally, just a few quick notes. For those who engage in electronic filing (as opposed to walking up to the clerk's office and stamping the document in), please note that electronic filing does not extend the business day. The business day at the Workers' Compensation Appeals Board ends at 5:00 p.m. If you do not have your document filed by then, it is not deemed filed until the next business day, and that may be too late. That was the sad result with the defendant in Breshears v. Kroger Company, 2013 Cal. Wrk. P.D. Lexis 299, where defendant electronically filed its Petition for Reconsideration on the last day that it was due, but at 5:32 p.m. And this was deemed untimely.

Another "sleeper" regulation is Rule 10450(e). This rule requires that all petitions and answers (we do not believe this includes answers to Applications for Adjudication of Claim) are to be verified, or they may be summarily disregarded or denied.

VIII.

CONCLUSION

There are still a number of issues that will likely become more defined over the next six months or so. There is a so called "Return to Work Fund" established by Labor Code § 139.48 which, while it does not have a direct affect on us, could indirectly affect the defense by providing an alternative fund from which workers (who are defined as having earnings losses disproportionately high relative to what they would expect on their disability ratings) can obtain supplemental compensation. Of course, if disability ratings are based upon what vocational experts have to say, then perhaps eligibility for that money cannot be established. However, there is about $240 million there right now, and no one has apparently come up with any interim rules with respect to how to deal with it.

There are some pending cases of interest before the Workers' Compensation Appeals Board involving the limitations on consequential psychiatric claims set forth in Labor Code § 4660.1(c). Applicant's attorney's are making a somewhat interesting argument that the language in this section (relating to the allowance of a consequential psychiatric claim in the case of catastrophic injury or violent act) has the effect of superseding the substantial cause/predominant cause limitations set forth in Labor Code § 3208.3. It is unclear whether this is one of the cases presently there, but if not, it likely will be soon.

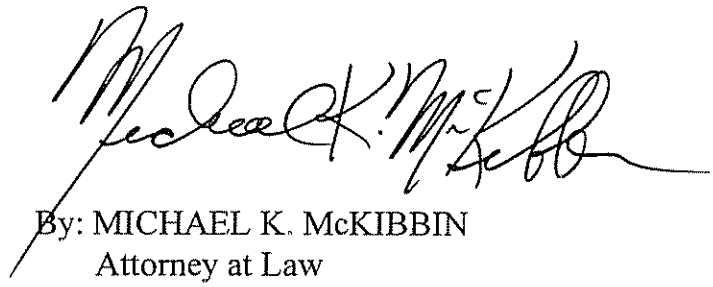
Quite frankly, we think we are probably going to see greater use of vocational experts. The only control with respect to this is CAAA's admonition to its members but they probably need to pay the experts up front, and seek reimbursement from the carriers, otherwise the vocational experts are not going to want to perform services. This will hopefully cause applicant's attorneys to be somewhat selective with respect to the cases in which they decide to pursue this remedy.

By the time of the next convention, we should have a clearer understanding with respect to how the Utilization Review/IMR issues should work. Hopefully, we will also be seeing a greater degree of acceptance with respect to the use of MPNs, where they exist.

We are pleased to have been able to present this paper to you. Our firm will be more than happy to answer any questions you might have in connection with the topics presented in this paper, and we are more than willing to discuss any issues you may have with respect to workers' compensation, whether related to specific or general issues. We are available for continuing education seminars, and encourage you to contact us for such events.

Very truly yours,

BENTHALE, McKIBBIN & McKNIGHT



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