BENTHALE McKIBBIN & McKNIGHT
A Professional Law Corporation

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

Shareholders:
EDWARD J. BENTHALE
MICHAEL K. McKIBBIN
E. H. McKNIGHT, JR.
THOMAS J. BELL

Partners:
ROBERT A. MATA

Associate Attorneys:
HAROLD Y. HATA
ANDREW K. BORG
NATHAN A. SCOTT
DARLA P. GRETZNER
JACK S. MACK
ANITA MORADIAN
JONATHAN P. BITZ
CHRISTINE A. ELLIOTT
DORNA JAVANFARD
DYLAN GOLDEN
BRITTANY ROTHE-KUSHEL

Of Counsel:
GERARD R. DAGONESE

DEFENDANT'S ATTENDANCE TO CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION 2018 WINTER CONVENTION

2018 WINTER CONVENTION OF THE
CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION
JANUARY 25 – 28, 2018

TABLE OF CONTENTS

INTRODUCTION

Once again, our firm attended California Applicant Attorney's Convention that commenced on January 25, 2018 and completed on January 28, 2018. The convention was well attended. The materials presented were most informative. In addition, by attending this convention, we are able to make a determination as to the continuing trends from the point of view of the Applicant's Bar. In summary, there were a considerable number of sessions addressing the primary concept, that being, workers' compensation laws are designed for the "delivery of benefits." With that said, considerable amount of time was spent on demonstrating how the actions of Defendants cause for a breakdown in the delivery of those benefits. As such, there were a number of sessions dealing with subjects to include Medical Provider Networks, the use of Panel Qualified Medical Examiners, the issues surrounding Requests for Authorization, and general practice tips to assure their clients receive benefits. In addition, there were presentations on the changing labor demographics, recent case law and the commissioner's panel. Over all, the continuing theme at the conference was the perception Defendants take actions that cause considerable detriment to their clients. As such, the continuing message was to bring ideas to the participant that would facilitate them in being successful in obtaining the maximum amount of benefits they can on behalf of their clients. These actions are professed to be necessary in light of the fact they consider institutions such as the Panel Qualified Medical Examiners, the Industrial Medical Counsel, the Medical Provider Network to be flawed. With that said, we hope you find the following read of interest.

I.

MEDICAL ISSUES

A. QUALIFIED MEDICAL EXAMINER – THE QUAGMIRE:

First and foremost, the focus was on the fact there are not a sufficient number of Panel Qualified Medical Examiners in the State of California. Apparently, there are currently 2,500 listed Panel Qualified Medical Examiners. When the system began, there were 5,000 Panel Qualified Medical Examiners. The moderator brought forth facts to suggest many Panel Qualified Medical Examiners are being disqualified to participate. Infractions include erroneous billing, consistent non-compliance with time requirements and multiple challenges by the parties. Furthermore, they advise a careful review of the panel issued by the IMC is required in light of the fact many physicians names are accompanied by an asterisk. Those identified by an asterisk are known to the IMC as those physicians who are on their "wall of shame." A point is made, however, an asterisk is not to be construed as a negative mark on their qualities as a physician. They simply deviate from the standards imposed by the IMC.

Strategically, the moderators would suggest an Applicant's attorney choose the worst of the three physicians on the Panel. Clearly, a subjective point of view. They will take this course of action in light of the fact their primary intent is to ultimately rely upon the Primary Treating Physician's report. All parties acknowledge there is no presumption of correctness between the Primary Treating physician and/or the Panel Qualified Medical Examiner. In addition, there is much discussion on when to apply for a Panel. All moderators agreed it was best to apply for a Panel as early as possible. They would recommend they utilize the Defendant's delay letter in preparing that request. (The delay letter issued by the claims examiner). The position taken is the delay letter sets forth an issue which can now be addressed by the Panel. Their focus, of course, is to obtain a Panel that will find a favorable opinion on behalf of their client.

Given the fact many Applicant attorney's rely upon the Primary Treating Physician as a Med-Legal report, there was much discussion with regard to same. All attorneys were advised the Primary Treating Physician can only prepare a Med-Legal report once the Panel Qualified Medical Examiner has weighed in. By definition, a Med-Legal report is to address a disputed Medical-Legal issue. Therefore, all attorneys were counseled as to not to rely upon a Med-Legal Primary Treating Physician report if it was prepared in advance of the Panel Qualified Medical Examiner's report. The only exception to this rule would be when the case has been denied. With regard to claims that have been denied, the Primary Treating Physician can be called upon to prepare a Medical-Legal report addressing AOE/COE.

B. MEDICAL PROVIDER NETWORKS - DO THEY DO THEIR JOB?

The position taken by the moderators was the fact that they believe there to be a broken MPN system that is ripe for legal challenge. There was considerable discussion on Code of Regulations 9767.5. Said regulations bring clarity as to the Medical Provider Network requirements that must be adhered to by the defense community. Furthermore, stated under the regulations, the MPN policy shall ensure that an appointment for initial treatment is available within 3 business days of the Applicant's receipt of request. As you might expect, the moderators chose to focus on what they believe to be deviation from this activity. All recognize, however, that the regulations do provide a time frame of up to 20 business days for receipt of a referral. One moderator brought to the table the fact that he has many clients who end up relocating outside the State of California. The moderator explained in detail how his clients are unable to obtain treatment within the state that they have resided in. The moderator provided legality for their position that the Defendants must take action to provide their clients with medical treatment outside the geographical area when the facts suggested same. Again, under the regs 9767.5(2)(e)(1), the written MPN policy is to identify 3 physicians outside the geographical area.

As a practical matter, we Defendants do see cases in which an Applicant's attorney may argue their client has not been afforded access to a Medical Provider Network physician. In the real world, we typically get those issues resolved with communications. Again, the primary focus of the Panel was to utilize these scenarios to a litigious standard. Again, the Moderator suggests all attorneys to rely upon reg 4616.85(2) wherein the law requires the medical access assistant shall provide timely access to a physician. If not, that a DOR be filed in order to seek a hearing on the issue.

C. REQUEST FOR AUTHORIZATIONS, UTILIZATION REVIEW & INDEPENDENT MEDICAL REVIEW

Again, the general consensus of the Moderators is that Defendant's actions curtails the delivery of medical benefits to their clients. The Applicant's Bar takes a position that, while the intent of the workers' compensation medical system is to provide injured workers with their medical benefits, the system in itself is complicated and causes for unnecessary delay. A considerable focus of the panel was on the subject of Request for Authorizations. Amongst the Moderators presenting included Dr. Bruce Fishman, M.D. and Dr. Brendan Morley, M.D. As such, the topic of Request for Authorizations was addressed from the medical perspective. The Moderators reminded all as to their requirement to prepare RFA's when seeking authorization for medical care. Their focus was upon the burdens that are placed upon them and their recommendations to better the success of medical authorizations. As to burdens, they would advise a five doctor group will prepare anywhere from 2,500 to 5,000 Requests for Authorization monthly. Of note, there is a significant amount of Requests for Authorization simply to address medications. They would further advise they would require in excess of 380 hours monthly in Peer Review and responding to Utilization Review inquiries and/or denials. As to recommendations, they enlighten all attorneys to assure all legal requirements have been met by the Defendants when RFA's have been decertified through Utilization Review.

They include the following:

- Did the Defendants send all the required medical records?
- The physician must show the functional improvement to the recommended treatment.
- At no time shall the RFA identify "there has been no improvement."

As might be expected, while they (the physicians) are dismayed with the Utilization Review process, they are even more dismayed by the Independent Medical Review requirements. The common theme was IMR is the most destructive and obstructive vehicle in which to deny an injured worker their medical benefit. They consider such action a denial of due process to the injured worker.

With all that said, the Moderators recommended legal action be taken as it relates to both Utilization Review denials and Independent Medical Review requests. As to Utilization Review, the BAR was advised to pay close attention to the timing of Defendant's response time on Utilization Review action. While it is generally recognizable Defendants have 14 days to respond to a Request for Authorization, rule 10109 sets forth reduction in time requirements if the necessary treatment is considered emergency treatment. The BAR is instructed to take legal action when these deviations occur. In addition, the BAR is instructed to take aggressive legal action in response to their conclusion that Defendants have not properly responded through Utilization Review or a request for Independent Medical Review. The focus upon whether Defendants have properly submitted all medical evidence as requires. The recommendation is made that a DOR be filed seeking costs and sanctions against Defendants for bad faith actions.

Practically speaking, while the advice was most informative for the Applicant's BAR, it is this editor's opinion that most of Applicant's BAR will not take any such action as recommended. Yes, there are times in which Applicant's attorney will challenge whether Defendants have properly and timely taken action in response to Utilization Review or application for Independent Medical Review but it is unlikely an Applicant's attorney is going to take the time to contact a doctor to assist him in preparing a Request for Authorization or, in the alternative, take an action in court for bad faith actions for not submitting **all** the medical records required for an application for Independent Medical Review. Yes, there are times, through inadvertence, in which all medical records are not forwarded but clearly such an action by Applicant's BAR would only be in response to when the Defendants take **no** action whatsoever.

D. THE COST OF MEDICAL BENEFITS

Finally, there was great discussion on the cost of providing injured workers medical treatment in the State of California. They brought forth statistics that would suggest California cost of benefits is greater that in most other states in the nation. However, their focus was not on the fact that California demands much in the way of administrative costs with a delivery of benefits system but the fact there is substantial costs in administering over the denial of benefits. They take the position the cost to deny treatment ought not to be included within the actual cost in delivering medical benefits.

II.

PROCEDURAL TACTICS

In this session, Moderators advanced what they considered to be common defense tactics harmful to their clients. The general theme advanced was that the Defendants have forgotten that the workers' compensation system was designed as a "delivery of benefits system." The primary focus by the moderators was upon rules and regulation 10109. We all know that regulation as the old law defined as "duty to investigate." There was much discussion regarding the 90 days to investigate a claim. There was much discussion in litigating issues to include the failure by Defendants to investigate a claim within 90 days. In addition, raising the presumption of compensability when Defendants do not timely complete their investigation. Generally speaking, and from a practical point of view, we Defendants do conduct our discovery within the 90 days. Be that as it may, recommendations were made that Applicant's attorney file request for Mandatory Settlement Conference with the intent to seek cost and sanctions when they believe Defendants have not properly complied with the 90 days for discovery requirement. There was nothing new brought to the table form what we Defendants already know.

There was a general discussion on how cases proceed from the medical point of view. The general consensus is that doctors take direction from administrators. There were general discussions regarding organizations like U.S. Health who no longer are vested in the 100% interests of the injured worker. A suggestion is made the business model of an institution like U.S. Health and others hampers the physician in their medical approach. There was a general consensus there are no longer any well-known go-to Applicant treating physicians. (Apparently the general consensus was those go-to doctors provided excellent and necessary medical care, we Defendants would disagree). There were discussions regarding use of nurse case managers. Most attorneys on the DEAS consider nurse case managers to be spies on behalf of the Defendants. However, one of the moderators did suggest there are times in which a nurse case manager would be beneficial particularly with regard to that "difficult client."

In addition, there was much discussion on the denial of treatment on a claim. The primary issue goes to a scenario where there is one part of the body that has been admitted while a second part of the body has been denied. They consider their clients to be at a disadvantage when they seek treatment. They acknowledge a physician will advise their patient they cannot treat an ankle injury when it has not been pled nor when it has not been authorized by the Defendants. The Applicant's bar considers this concept to be a denial of medical care. They advise their members to challenge these issues. They suggest filing for a hearing seeking a judicial input. They cannot file for an Expedited in light of the fact the part of body has not been admitted. As such, they suggest filing for a Mandatory Settlement Conference. In so doing, they can pave the way for Trial on the issue. By taking this action, the Applicant's Bar is hopeful the Defendants will acquiesce to their position. A common perception by the Applicant's BAR is that Defendants have forgotten that the workers' compensation system is a "delivery of benefits system." The Applicant's BAR takes a position that Defendants take action that causes further delay of providing those benefits. As such, the overriding message was "do not fear trying the issue and/or the case." Recommendations were made that action be taken to Subpoena the adjuster and/or the employer both for participation at the Trial level. Recommendations were made that all attorneys conduct themselves in a courteous but effective manner. There were points of contention between those who presented as to how courteous they should be. Be that as it may, a significant recommendation was that all Applicant attorneys should file a Declaration of Readiness following receipt of Primary Treating Physician's report from which the Primary Treating Physician had deemed Applicant to be at Maximum Medical Improvement. In so doing, an attempt is made to obstruct the Defendant's opportunity in seeking an opinion from a Panel Qualified Medical Examiner. Of note, such advice is only noteworthy when the PTP report can be considered substantial medical evidence on all medical and legal issues.

Given the advice regarding the Primary Treating Physician, we Defendants (when it makes sense) should always taken action to enter an objection to the findings of the Primary Treating Physician. The Applicant's BAR is relying upon their assessment that

Defendants delay such action. This advice on its face is certainly relevant when you have a well-written Primary Treating Physicians report that addresses all issues. Conversely, however, the Applicant attorney's bar realizes their go-to Primary Treating Physicians are far and few between given the fact most Applicant's treat within the Medical Provider Networks. In the end, the common theme was to move the Applicant's case aggressively with no fear of moving towards Trial.

III.

LABOR DEMOGRAPHICS

While the focus by the Moderators was to better prepare Applicant's attorney to litigate their cases, much focus was also granted to the changing demographics of the workforce. This panel was summoned to provide a future snapshot as to how the Applicant's practice may be impacted as changes are forthcoming. Those changes included the average age of an injured worker, their political affiliation, their attitude, and their education.

There was much discussion regarding a contingent workforce. The definition of a "contingent work force" is another way of saying "part time work force." Going forward, a contingent workforce is the fastest growing sector of employment. At the present time, 20% of all jobs nationally are considered a contingent position. The average worker in the contingent group works 26 hours per week. The percentage of those in the contingent work force will grow year to year. This brings us to the demographics of the changing workforce. In the year 2020, 50% of all employees will be at an age of 34 or less. In the year 2025, 75% of the workforce will be at an age of 44 or less. Going forward to the year 2020, 67% of the workforce will not have attained a college degree. 43% of the workforce in the year 2020 will be non-white. 22% of the workforce will live at or below poverty level. By comparison, baby boomers when at the age of 35, only 7% lived at or below poverty level. That number is now 22%. That segment of the workforce in 2020 that is 34 years of age or less will register practically as independents. There is no stringent political affiliation with that age group. Of significance, however, that age group as they move forward demonstrate a 54% probability of becoming an entrepreneur rather than being employed. Finally, the average time spent on one job is 3 years.

With these professed statistics, there was a general pause by the audience, particularly amongst the younger in age attorneys.

IV.

COMMISSIONER'S PANEL

A most interesting and insightful look into our Workers' Compensation Appeals Board panel. Currently, we have five commissioners addressing cases for reconsideration. Of note, there continues to be two vacancies remaining to be filled. The suggestion from the Moderators was the governor does not place this issue before him as a matter of urgency. There were references to budgetary issues. However, Commissioners do rely upon the work up of a Deputy to assist them in their legal analysis. Currently, they have the assistance of 13 Deputies. Of interest, 9 of the 13 have less than 4 years of workers' compensation legal experience. Currently, the Commissioners are looking at 300 pending cases. The oldest case going back to 2015. Of the 300 cases, they estimate 30 are to address whether an injured worker is deemed 100% disabled.

A request was made of patience by all those in the audience. The general message going forward was that all Commissioners and their team are working diligently within the parameters that govern them.

V.

MOST IMPORTANT CASES

As is tradition at the CAAA convention, an extensive period of time was extended to addressing new cases for consideration. Cases addressed cover a wide range of Medical Legal issues. They are summarized as follows:

Federal Express Corporation v. WCAB (2017) 82CCC 1014, writ denied

The significant legal issue addressed in this case was whether the Workers' Compensation Appeals Board enjoyed jurisdiction for contractual language found within the body of a Compromise and Release settlement agreement. The issue arose as to whether any and all treatment provided to an injured worker was subject to Utilization Review/Independent Medical Review or subject to the terms found in the Order Approving Compromise and Release settlement agreement.

The underlying case stemmed from a Federal Express employee who entered into a Compromise and Release with the Defendants from which the terms of the Compromise and Release allowed for ongoing future medical care. However, the language of the Compromise and Release specifically indicated Agreed Medical Examiner Dr. Peter Mandel would be the "ultimate medical arbitrator" regarding the medical necessity for claimed industrial treatment. Factually, and as was expected, Applicant continued to seek treatment subject to the Defendant's action taken through Utilization Review/Independent Medical Review. The Applicant filed a request for Expedited Hearing seeking an order for medical treatment. Defendants relied upon the Utilization Review/Independent Medical Review denials. The Trial Judge found that there was no jurisdiction to determine the medical dispute. As such, the Defendants prevailed on relying on provisions of the Utilization Review/Independent Medical Review. Applicant petitioned to the Workers' Compensation Appeals Board with an unanimous decision reversing the workers' compensation Judge's decision and found that the Court did, in fact, have jurisdiction to

enforce the contractual agreement pertaining to the resolution of the medical dispute. The Board relied on Labor Code §5300 and §5301 wherein the Appeals Board enjoys the exclusive forum to try to determine all disputes concerning recovery of compensation. In addition, the Judge did, in fact, enjoy jurisdiction to enforce the contractual language found within the Compromise and Release.

Clearly, a unique scenario that certainly stands for the proposition there are exceptions to the general conclusion that the provisions of Utilization Review/Independent Medical Review are not always absolute.

Sandra Catlin v. JPC Penny, Inc., (2017) work comp P.D. Lexis 106

This is a Board Panel decision addressing the provisions of Labor Code §4050. Labor Code §4050 provides statutory rights for a party to have an Applicant evaluated by a physician of their own choosing and at their own expense. In Catlin, the Applicant and Defendants entered into a Compromise and Release wherein the terms of the Compromise and Release allowed for the Applicant to seek ongoing future medical care. The settlement was based upon the findings of Agreed Medical Examiner Dr. William Mouradian. Subsequently, Applicant sought to seek medical care as ordered through her primary treating physician. Although Utilization Review approved the request for treatment Defendants denied. Defendants' intent was to have Applicant examined by Dr. Brian Grossman via Labor Code §4050. Under Labor Code §4050, either party may obtain a medical opinion at their own cost. The matter came up for Expedited Hearing where Defendants argued their entitlement to a Labor Code §4050 examine. The Judge issued a Minute Order requiring the Applicant to be examined by AME Dr. William Mouradian pursuant to Labor Code §4050. Defendants petitioned for Removal of this Order.

The WCAB issued a ruling indicating the Trial Judge was incorrect in referring Applicant to Dr. Mouradian under Labor Code §4050. More importantly, Labor Code §4050 was not the proper vehicle. The proper vehicle would be under Labor Code §4060, §4061 or §4062. The Court relied on McDuffie vs. Los Angeles County Metropolitan Transit Authority (2003) 67 CC 138 where an injured worker should be examined by a physician who already reported on the case. In this case, Dr. Mouradian.

Ultimately, the decision reached was Labor Code §4050 has limited value. The medical reports obtained through Labor Code §4050 are not admissible and cannot be forwarded to medical/legal evaluators for review. As such, while Defendants desired a §4050 exam, the resulting report is inadmissible at Trial.

Comp West Insurance v. WCAB (Gonzales), 628 2017 (82 Cal.Comp case 897 writ denied)

The primary issue in this case was whether the judicial finding that Applicant was deemed 100% disabled was based upon substantial evidence. In this case, all medical evidence as rated by the DEU demonstrated Applicant having a 92% whole person impairment. At Trial, Applicant brought forth a vocational evaluator who deemed Applicant unable to participate in the work force. The medical/legal issue addressed was whether the medical evidence standing alone supported a finding of total permanent disability. At the Trial level, the Judge found that Applicant was, indeed, 100% disabled based upon the totality of evidence presented to him. The evidence included Applicant's testimony, vocational reports both by the Defendants and the Applicant and the medical evidence submitted. Upon a Petition for Reconsideration, the Board determined that the entire record supported the conclusion that the injured worker was not able to benefit from vocational rehabilitation or reenter the work force and therefore deemed 100% disabled.

The facts of this case is not all that uncommon to the Defendants. The difficulty with this fact pattern was the indication Applicant was at 92% whole person impairment based solely on the medical evidence without consideration of the vocational rehabilitation expert. The decision might have changed had it been determined Applicant was at whole person impairment at a much lower amount such as 65%. In this case, Defendants were unsuccessful in arguing for a decision at 92% Whole Person Impairment based solely on the medical evidence and their vocational expert. The case stands for the legal concept of "substantial evidence" and, in this case, more substantial for the Applicant.

Roger Bass v. State of California, Department of Corrections & Rehabilitation (512 2017 82 Cal.Comp case 1034)

The primary issue addressed in this case is whether it is appropriate to have multiple body parts claimed in one cumulative trauma injury. In addition, where there are several parts of body resulting in separate extensive disability and whether the disability should be combined (CVC) or added in order to determine the extent of disability.

In this case a law enforcement officer claimed one CT injury for parts of body to include heart, neck, back, right knee, left foot. AMEs were obtained to address the parts of body claimed. The issue at Trial (as brought forth by the Defendants) was whether there was one single cumulative trauma injury involving all parts of body or whether there should be two separate dates of injury. One for the cardiac claim and one for the orthopedic claim. The evidence suggested same. The Trial Court concluded there was but one date of injury that being the cumulative trauma claim file. The Board agreed. The Board reached their decision on the evidence presented. The evidence included the Applicant's testimony that he did not realize he had a cumulative trauma injury until such time he consulted with an attorney and furthermore, the substantial medical evidence did not support the Defendant's position. The Board further ruled as to the issue regarding whether disability should be combined or added. This is an issue that must be addressed by the medical evidence. In this case this medical question was not adequately addressed by the Agreed Medical

Examiner. As such, the Board remanded the case back to the Trial level for additional discovery.

When confronted with these sets of facts particularly with cumulative trauma claims this ruling sets forth the proposition that this issue must be addressed through the medical community. The proper questions must be presented to the Panel Qualified Medical Examiner or Agreed Medical Examiner in order to lay the foundation for moving forward.

Ruth E. Lugo v. County of Los Angeles, 2017 Cal. Wrk. Comp

This is a case that addresses evidence. The primary issue going forward was whether a report by Dr. Sobel to be considered admissible at the time of Trial. The facts of the case would suggest Dr. Sobel entering his medical opinion and report prior to the time he was suspended from participating in a workers' compensation matter based upon a fraud conviction. At Trial, the workers' compensation Judge relied upon the reporting of the suspended physician. Defendants petitioned for reconsideration.

The Board relied upon Labor Code §139.2. The language of the code provides no authority on an action of suspension. Therefore, the Trial Judge was correct to rely upon the evidence presented to him, the Applicant's testimony and the medical opinion offered by Dr. Sobel. The Board reached its conclusion on the basis that Labor Code §139.2 specifically provides circumstances from which a QME report would be excluded but in this case there is no such language regarding a physician who was suspended for fraud.

No doubt Dr. Sobel wrote a liberal opinion from which the Trial Judge relied upon. The Defendants did their best under this scenario.

Pearson Ford, et al., vs. WCAB (Hernandez) 4th App. District. Certified for publication at the request of the State Board of Workers' Compensation Committee (filed 10/06/17), 82 Cal.Comp. 1105

The primary issue in this case is whether an injured worker who was convicted for insurance fraud would be barred from a recovery of 70% permanent disability award. In this case the injured worker was, in fact, awarded a 70% disability.

The Applicant, a body shop technician suffered a crushing injury to his left hand. The Applicant was examined by Agreed Medical Examiner Dr. Byron King who concluded the Applicant suffered complex regional pain syndrome and reflex sympathetic dystrophy. AME reviewed *Sub Rosa* films and was not persuaded that his opinion should change. The AME concluded the complex regional pain syndrome and reflex sympathetic dystrophy was caused by the injury and medically supported.

Prior to Trial and prior to the Agreed Medical Examiners examination of the Applicant, Applicant was convicted for insurance fraud for making a false statement. He entered a plea bargain of no contest/guilty and agreed to restitution of $9,000.00. The Defendants relied upon Tensfeldt v. WCAB (1998) 66 Cal.App.4th 116, 63 CCC 973 to advance their position that Applicant was barred from an award. In that case, an Applicant in certain situations may be completely barred from receiving workers' compensation benefits for an injury that was also the subject of Applicant's conviction for insurance fraud in violation of Insurance Code §1871.4(a)(1).

At the Trial level, the Judge issued an award of 70% disability based upon the medical evidence. The Defendants raised the findings of the Tensfeldt case. On Petition for Reconsideration, the Board denied the petition on the basis that the Defendants had misapplied the provisions of Tensfeldt. The Court of Appeals accepted the case. The Court of Appeals affirmed the Board's decision. The Court agreed that the Tensfeldt decision was the leading case and pointed out that the decision did not provide a broad

prohibition of benefit payments not directly connected to the fraudulent misrepresentation. The Board issued a test for determining whether a conviction bars a recovery and the test is as follows:

1. The existence of an otherwise compensable actual injury;
2. Substantial medical evidence supporting an award not stemming from the fraudulent misrepresentation upon which the conviction was based;
3. The Applicant's credibility was not destroyed by the fraudulent conduct.

A most difficult case for the Defendants. As much as we would like to accept the proposition that once a fraud always a fraud this will not apply. The Moderators of course agreed with the opinion of the Appeals Court and advanced the fact that Applicant had been charged with insurance fraud on the issue of receiving Temporary Total Disability Indemnity on false evidence. Therein lied the issue. While there was fraud on the issue of TTD, the Trial Judge, the Board and the Appellate Court ruled no connection between TTD and the award of permanent disability.

Blanco Ayala v. Fruit Harvest, Inc./Garr Ins. Company (August 2017) 45 CWCR 180.

A most interesting case addressing all issues to include AOE/COE, personal comfort doctrine, special risk of harm.

The Applicant, a farm worker was picking fruit on behalf of the employer. On the day of injury (06/01/2015) Applicant testified it was "really hot". At lunch time, the Applicant with the rest of his crew and his supervisor moved across the street to a peach orchard to rest. The peach trees provided shade. Applicant napped. The orchard was not a part of the employer's premises. The Applicant and crew thought it was. While taking a nap, Applicant was run over by a truck. The truck driver chose not to utilize the road because it was congested with field workers and decided to drive on the orchard property. The Defendants denied the case on the basis Applicant was on his lunch break, not on the

employer's property and the accident was caused by a third party. At the Trial level, the workers' compensation Judge found the injuries to be compensable.

The Board affirmed the Judge's decision on several grounds. The Panel first addressed the personal comfort doctrine. The Board concluded the personal comfort doctrine is not limited to acts performed on the employer's premises. The Court noted the Defendant employer failed to provide its workers with shade as mandated by State regulations. As such, the personal comfort doctrine applies when the injured worker elected to cross the street, obtain shade at an orchard not owned by the Defendant.

The Panel also applied the special risk of harm doctrine. The doctrine required:

1. The injury must be causally related to the employment and;
2. The risk must be distinctive and qualitatively greater than risks common to the public.

In this case, the Applicant was driven to the work site by his supervisors. The Applicant had no way of leaving the work site at the time of the lunch break and furthermore followed a supervisor to rest with the crew. The Board reasoned the location of the injury, that being the peach orchard places the Applicant in a special risk of harm when the truck ran him over.

Finally, the Board reasoned by locating the crew across the street as suggested by the supervisor gave implied consent to use the shady orchard. The Board concluded the employer had violated California Heat Illness Prevention regulations Code 3395(d).

This clearly was a fact sensitive case. On first impression, the case was deemed ripe for denial. However, when peeling back the facts, those facts favored the Applicant when the elements of the law were applied. (No pun intended).

Maureen Hikida v. Workers' Compensation Appeals Board, Costco Wholesale Corporation WCAB #ADJ 7721810

This is a certified for publication case on the issue of apportionment. The issue goes to the legal concept of "causation". The Applicant, a clerical worker for Costco filed a claim for carpal tunnel syndrome of the upper extremities. Applicant was a 25 year employee. Applicant underwent carpal tunnel release surgery. Following surgery Applicant claimed her symptoms increased. The medical community ultimately concluded Applicant suffered from chronic regional pain syndrome. Applicant was examined by Agreed Medical Examiner Dr. Chester Hasday. Dr. Hasday concluded Applicant was permanently and totally disabled from the labor market. He opined the Applicant's permanent total disability was caused entirely by the effects of chronic regional pain syndrome which she developed following the failed carpal tunnel surgery. He also offered a second opinion that Applicant's underlying carpal tunnel syndrome was itself 90% apportionable to the industrial injury with 10% to non-industrial factors. The matter proceeded to Trial on the issue as to whether Applicant was 100% disabled or 90% disabled after adjustment for apportionment. The workers' compensation Judge found Applicant to be 90% disabled based upon the provisions of Labor Code §4663. That being the Judge must take into consideration all issues of apportionment and permanent disability to factors other than the Applicant's industrial injury. The Applicant filed a Petition for Reconsideration. On a two to one decision, the Board affirmed the Judge's decision. The majority concluded "to properly evaluate the issue of apportionment of permanent disability, it is necessary to partial out the causative forces of the permanent disability, non-industrial, prior industrial and current industrial and decide the amount **directly** caused by the current industrial source. The Board, however, raised caution to the wind when the workers' compensation Judge failed to take into consideration other reports suggesting Applicant suffered employment related psychiatric injuries (another way of saying that Applicant may have been deemed 100% disabled if the Judge had considered those reports). As such, the Board remanded the matter back to the Trial level. At Trial the WCJ increased the disability to 98%. The Board denied reconsideration finding that the

apportionment was appropriate as previously opined. That being the 10% non-industrial to the underlying injury was applicable. 90% of Applicant's disability was caused by the industrial injury and 10% was caused by non-industrial factors.

The Appellate Court disagreed. The Appellate Court granted considerable discussion to the legal concept of causation. The Appellate Court relied on the AME's opinion that 100% of Applicant's disability resulted from failed surgery following the carpal tunnel release. The Appellate Court stated "our review of the authorities convinces us that in enacting the 'new regime of apportionment based on causation', the legislator did not intend to change the law requiring employers to pay for all medical treatment caused an industrial injury, including **the foreseeable consequences** of such medical treatment." The Court further noted "nothing in the 2004 legislation had any impact on the reasoning that has long supported the employer's responsibility to compensate for medical treatment and the **consequences of medical treatment without apportionment**. As such, a findings that 100% of Applicant's disability was caused by the failed surgery and, therefore, apportionment to non-industrial factors.

A significant case with regard to causation. Given this Appellate Courts decision we will expect Applicant's attorneys (when the facts apply) to work up their cases in a manner that focuses on disability that results from medical treatment and not from the underlying industrial injury.

V.

CONCLUSION

Again, the CAAA Convention was well presented and brought forth thought provoking ideas. Those ideas of course are directed to the benefit of the Applicant's Bar. By attending this conference, we obtain an advantage in knowing and understanding current trends from the Applicant's Bar's perspective. In so doing, we are hopeful we can become better litigators on behalf of the Defendants. We are hopeful you found this to be an interesting read and certainly welcome any questions or concerns you may have with regard to same. We remain available to address any questions you may have either by telephone, email, letter, or by way of continuing education seminars.