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DEFENDANT'S ATTENDANCE TO CALIFORNIA APPICANTS' ATTORNEYS ASSOCIATION 2019 WINTER CONVENTION

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CALIFORNIA APPLICANTS' ATTORNEYS ASSOCIATION

WINTER 2019 CONVENTION

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CAAA WINTER 2019 CONVENTION

We were in attendance at the January, 2019 winter convention of the California Applicants' Attorneys Association, and the following is a report of our impressions, observations, and analysis with respect to the various subjects discussed over the course of the convention. As usual, the primary theme is maximizing money, although the focus from convention to convention does tend to shift to various strategies. At this convention, the focus appeared to be on circumventing the schedule by way of vocational analysis and eliminating apportionment, so we take a look at those issues, as well as several other topics which have the potential of impacting our side of the practice.

Obviously, there are some severely injured and disabled workers out there, but the thrust of the convention is that virtually everyone injured on the job becomes severely disabled. That, of course, causes the process to become very litigious, although some of the more extreme suggestions that we are seeing simply may not be practical in routine cases. Some of the ideas, in fact, might be significantly impacted by the Fitzpatrick decision (discussed below) impacting the attempt being made over the past few years by applicants' attorneys to establish total disability "by the fact", pursuant to the somewhat vague provision in Labor Code section 4662(b) (one panel member called the decision abominable).

Procedurally, the Workers' Compensation Appeals Board is back up to full strength, with seven Commissioners. The Commissioners advise that they are trying to clear out the backlog of old cases in connection with which reconsideration was granted for further study, following which nothing happened (these cases go all the way back to 2015). As some of us know with these cases, retired Workers' Compensation Judge David Hettick has been tapped by the Commissioners to act as a mediator with respect to these cases to try to get them settled, and they report his efforts have been tremendously successful in resolving a large percentage of these cases.

In the next few months, it is our understanding that the medical treatment utilization schedule is going to be amended by incorporating the current ACOEM guidelines (the present schedule is a hybrid between ACOEM and other guidelines developed by the Director). The Department of Workers' Compensation is considering a proposal to pay the licensing fee for the use of the ACOEM guidelines, following which they would be freely available to frontline physicians, as well as utilization reviewers.

Utilization review is seen as another problem. It is reported that there are about 15,000 independent medical review requests per month. Until recently, the "uphold" rate was running around 90%, but the Administrative Director reports that the rate is dropping down to about 80%.

There are going to be some efforts to make utilization review more practical, and it sounds like the PR reports and the RFAs may actually be combined, so as to make it easier for the physician to reference the reasons for a particular recommendation.

The Commissioners and Administrative Director did address the procedures being used with fraudulent providers pursuant to AB1124. We were told that there are 154 stayed lien claimants, although they are given the ability to challenge the stays for individual cases (there is some concern that these challenges are developing a bit of a clog on the system). 342 medical and other providers within the system have been suspended because of convictions pursuant to Labor Code section 139.21. A fairly recent case, Barri v. WCAB, 83 C.C.C. 1643 (Court of Appeal, 2018), did hold that the anti-fraud legislation was constitutional, and, in response to the lien claimant's complaint that his inability to collect on what he claimed were "non tainted" liens interfered with his ability to obtain counsel for the purpose of defending himself, the court noted the legislation created a presumption that all of his liens were tainted by the misconduct, and also held that the lien did not represent property, but merely an "unreliable expectation of payment, contingent upon the satisfaction of several factors".

The Commissioners report that the number of liens in the system has been substantially reduced, and that a lot less liens are being filed at this time as well.

There is some concern with the Panel Qualified Medical Examination process. The number of available Panel Qualified Medical Examiners has dropped by about one-third over the years, with the result being that more QMEs are becoming unavailable, and certain specialties are not available. The remedy, we are told, is greater attempts to agree upon Agreed Medical Examiners or, in the alternative, petitioning the Workers' Compensation Judge to appoint a "regular doctor".

With all this in mind, we take a look at some selected substantive topics.

I.
IMPACT OF DYNAMEX

Long an issue in workers' compensation, but perhaps becoming more of one, is the status of a worker as either an employee or an independent contractor. This question is likely to arise more and more often with the so-called "gig economy", which is growing very quickly. The observation is made that many workers today do not fall neatly into either the employee or independent contractor camp. Labor Code section 3357 essentially provides that any person rendering service to another is presumed to be an employee, except as excluded from that status by law. Essentially, as noted in Yellow Cab Cooperative v. Workers' Compensation Appeals Board, 56 C.C.C. 34 (Court of Appeal, 1991), a worker is presumed to be an employee unless the hiring entity affirmatively proves otherwise (basically, the hiring entity has the burden of proof on the issue).

From a workers' compensation standpoint, since 1989, the test to be followed has been set forth in the Supreme Court case of S.G. Borello & Sons v. Department of Industrial Relations, 54 C.C.C. 80 (1989). In Borello, the Division of Labor Standards Enforcement issued a stop order/penalty assessment against a grower (Borello) for failing to secure workers' compensation insurance for its cucumber pickers. Borello argued that these workers were not employees, since they worked pursuant to a so-called "share farming agreement" in connection with which they were able to choose a portion of the crop area (first come, first served), and then service it for a couple of weeks prior to the harvest followed by picking of the cucumbers (all of which were sold to a single buyer). The workers were paid a portion of the sale price.

In rejecting Borello's argument and upholding the stop order/penalty assessment, the Supreme Court found that these workers were employees for a number of reasons, and established the so-called Borello test, which looks at the primary factor being the "right to control" (essentially over the methods and means of the work, but not the results, although having all necessary control as to overall operations suffices), coupled with multiple secondary factors:

(1) whether the one performing the services is engaged in a distinct occupation or business;

(2) the kind of occupation (whether generally performed under the direction of a principle or by a specialist without supervision);

(3) the skill required in the occupation;

(4) whether the principle or worker supplies the instrumentalities, tools, and place of work;

(5) the length of time for which services are to be performed:

(6) the method of payment (time or by the job);

(7) whether the work is part of the regular business of the principle; and

(8) whether the parties believe they are creating the relationship of employer/employee.

The so-called "gig economy" has complicated things. Some of the problem situations are unintentional, such as where an employee retires, then returns as a consultant or on a part-time basis as an independent contractor. Others appear more intentional, such as a company reclassifying its entire workforce as independent contractors (in effect, firing them, and then bringing them back in a new capacity). This is essentially what happened in Dynamex Operations West v. Superior Court, 83 C.C.C. 817 (Supreme Court, 2018). It is to be noted that this is not a workers' compensation case, but instead was a lawsuit by several of Dynamex's delivery drivers to force compliance with an Industrial Welfare Commission wage order. The Dynamex court noted that the Industrial Welfare Commission has the authority to promulgate wage orders, and to define the standard for determining when an entity is to be considered an employer for the purpose of a wage order. The wage order in question, which applied to the type of work delivery drivers were performing, basically defined the term "to employ" as "to suffer or permit to work". Dynamex extensively discussed the Borello test of employment in the workers' compensation context, and did not question the use of this test in the workers' compensation context.

In connection with wage orders, however (and the court specifically stated its opinion was limited to wage orders issued by the Industrial Welfare Commission), the court established a three-prong test, called the "ABC test": (A) the worker is free from direction and control in the performance of the service, both under the contract of hire and in fact; (B) the worker's services must be performed either outside the usual course of the employer's business or outside all of the employer's places of business; and (C) the worker must be customarily engaged in an independently established trade, occupation, profession, or business of the same nature as the service being provided.

The question, we suppose, is whether the application of both tests in any particular context necessarily produces different results. We do know that at least one Workers' Compensation Appeals Board panel (Leamon Perkins v. Don L. Knox, ADJ 10183569, October 23, 2018) has noted that Dynamex's court specifically limited the ABC standard to classification of workers under wage orders, and held that the Borello standard continued to apply in workers' compensation matters. Again, however, is the result necessarily different? Borello's multiprong test is not an ironclad list; a worker claiming to be an employee will rarely literally meet all of the criteria set forth in Borello. Rather, the Borello standard is actually a balancing test, and this probably makes it more favorable to employees.

The panelists seem to feel that, for employers, the real problem in Dynamex was the "B" portion of the test (worker's services performed either outside the usual course of the employer's business or outside all of the employer's places of business): if a worker is preforming a function which benefits the hirer in the course of the conduct of its regular business, under a wage order that person would be considered an employee.

Certainly, applicants' attorneys are looking for methods to expand the scope of Dynamex to workers' compensation, but the legislature has apparently seen this coming. Being proposed is an amended Labor Code section 2750.7, which would actually adopt the Borello standard as the appropriate test for apparently determining employment in all situations (and thus eliminate the Dynamex test for anything).

II.

FURTHER ATTEMPTS TO REBUT THE SCHEDULE

Although a change to the future earning capacity variant was made several years back (essentially, eliminating it), the present Permanent Disability Rating Schedule has been in effect since 2005. Originally considered somewhat ironclad, over the years the courts have allowed exceptions and variations to strict application. Although the Permanent Disability Rating Schedule (and all of its component parts) is considered presumptively correct, the criteria which has developed is that the Schedule must produce an "accurate" rating, and if another method encompassed within the four corners of the Guides produced a more accurate result then a rebuttal of the strict AMA rating was permitted.

The purpose of incorporating the AMA Guides into the Permanent Disability Rating Schedule was to promote more consistency with respect to ratings (under the old schedule, work restrictions or subjective complaints could vary dramatically from one case to another, depending upon who was doing the evaluating). It appears, unfortunately, that rebuttals have become more common, and the "accuracy" standard has become somewhat subjective.

In the context of total disability cases, Labor Code §4662 actually created presumptions of total disability outside of the Guides (loss of both eyes or blindness; loss of both of hands or their use; practically total paralysis; or brain injury resulting in permanent mental incapacity). Applicants attorneys for years argued that Labor Code §4662(b) also provided another avenue of establishing total disability independently of the Schedule, indicating that "in all other cases, permanent total disability shall be determined in accordance with the fact."

However that particular argument, underlying several of the presentations of this convention, was thrown into a bit of disarray by the Court Appeal decision in Department of Corrections and Rehabilitation v. Workers' Compensation Appeals Board (Fitzpatrick), 83 C.C.C. 1680 (2018) which held that Labor Code §4662(b) does not constitute a separate path for determining permanent total disability but, rather, outside of the specific injuries specifically identified in §4662(a), Labor Code §4660 (the Schedule) was the only path to determining 100% disability, and that "the fact" referenced in subsection (b) are the facts which are taken into consideration in reaching a rating under Labor Code §4660.

This case is obviously good for the defense, since it restores some order to the rating process.

A. Adding Disabilities Pursuant to Kite

Athens Administrators v. WCAB (Kite), 78 C.C.C. 213 (Writ Denied, 2013) involved a bilateral hip disability, in which applicant's disability ratings with respect to each hip were added together to produce a combined rating rather than utilizing the Combined Values Chart derived from the AMA Guides (and incorporated into the Permanent Disability Schedule set forth in Labor Code §§4660 and 4660.1). The Panels point out that application of the Combined Values Chart is not mandatory, and that is true; if the Permanent Disability Rating Schedule is rebuttable, any part of it is rebuttable. The Panel's point out that the AMA Guides themselves, which states that there is no specific formula showing the best way to combine multiple impairments. The argument is that the Combined Values Chart does not account for combinations of multiple impairments that can have a greater than additive effect on function, and possibly provide a lower whole person impairment than is functionally indicated. Again, the focus is on what is accurate.

If Kite is restricted to its particular circumstances, it is understandable. Kite involved disability to the same body system (the hips). Even in the later case of Diaz v. State of California, a 2015 Panel decision (2015 Cal. Wrk. Comp. PD LEXIS 683) where the Board determined that adding impairments with respect to the upper and lower gastrointestinal systems was appropriate, to a certain extent that involved the same body systems as well.

However, like what happened with Wilkenson before it, the case is expanding, involving different body systems. The watchwords seem to be either a lack of overlap between the disabilities, or that the combined disabilities have a "synergistic" effect. Thus, in Taina v. County of Santa Clara, 46 C.W.C.R. 214 (Panel decision, 2018), a psychiatric and orthopedic disability were added rather than combined on the basis of the psychiatric Agreed Medical Examiner's testimony that there was no overlap between the disabilities. (The doctor explained his position on lack of overlap by stating that applicant's orthopedic factors limited her physical capacity to work, whereas her psychiatric factors limited her mental capacity to work, a vague statement which is almost impossible to challenge, and which could conceivably justify an additive rating in any case involving orthopedic and psychiatric disability.) The WCAB suggested that it has the expertise to determine an accurate rating based on an entirety of the record, and in making such a determination, the schedule provides only a "guide" (which seems to be quite inconsistent with prior holdings that the Permanent Disability Schedule is presumptively correct).

A Panel decision in Eyad v. Airport Commuter, Inc. (ADJ 8010061) added orthopedic disabilities with respect to the back based upon the Agreed Medical Examiner's testimony with respect to the synergistic effect (noting that applicant was limited to seated activities, and required the use of a walker), to produce a rating of 98% (interestingly, the AME, Dr. Conrad previously used an Almaraz/Guzman analysis to incorporate a gait derangement into applicant's back disability, together with DRE III rating).

At least in these cases, the doctor was rendering the opinion with respect to what he believed to be a more accurate reflection of applicant's disability. Disturbing is Sanchez v. California Department of Corrections, 2015 Cal. Wrk. Comp. PD LEXIS 482, where the Agreed Medical Examiner deferred the issue of adding impairments to the trial judge, who thereafter added them instead of using the Combined Values Chart, a decision which was upheld on reconsideration (a similar result appears to have been reached in Martinez v. Pack Fresh Processors, 2017 Cal. Wrk. Comp. PD LEXIS 492).

A fairly recent case favorable to the defendant on this subject is Foxworthy v. Workers' Compensation Appeals Board, 82 C.C.C. 1192 (a Writ Denied, 2017), where the WCAB did hold that while the Combined Values Chart operates only as a guide for combining impairments, it should ordinarily be applied unless there is some overriding reason to use a different method of accounting for multiple disabilities (and this case did involve orthopedic and psychiatric disabilities).

B. Vocational Rebuttal

Over the years, attempts to rebut the Permanent Disability Rating Schedule by way of vocational evaluations have, unfortunately, become something of a way of life. The idea is based upon an argument that the numerical result of the rating string does not accurately reflect the impact of a disability on an individual's ability to compete in the open labor market and benefit from rehabilitation. The essential thrust of this Panel, it appeared, was utilization of vocational evaluation studies to avoid apportionment and establishing total disability in cases where the medical disability would probably come far short of warranting that.

Procedurally vocational evidence is submitted by way of report (Labor Code §5703(j); and the reports must comply with most of the same requirements imposed on medical reports in order to be valid (§5703(j); Regulation 10606.5). Those reports must address causation, and include an apportionment determination, according to Judge Feddersen, one of the Panelists. The factors which should be taken into consideration in vocational reports are those set forth in Labor Code §§4660 (or 4660.1), those being age and occupation. Impermissible factors have been identified as lack of education, poor language skills, status of the job market, general economic conditions, geographical area in which claimant resides.

With this in mind, Judge Fedderson tells us that if the disability percentage produced through use of the schedule does not accurately correspond with the irreversible residual of a work related disability that causes impairment in earning capacity, impairment in the normal use of a member or handicap in the open labor market, it can be rebutted by a vocational evaluation report. Judge Fedderson cited his decision (upheld on reconsideration) in Target Corp. v. Workers' Compensation Appeals Board (Estrada), 81 C.C.C. 1192 (writ denied, 2016), in which he felt that applicant's valid medical apportionment was not contributing to applicant's total loss of earning capacity and inability to compete in the open labor market (thus, a 100% case). He tells us that, in this manner, a vocational expert's opinion could completely negate medical apportionment. He tells us that vocational experts may actually be best suited to evaluate permanent disability, since doctors are not experts on earning capacity, occupations, and the labor market.

The Panel suggested that Contra Costa Co. v. WCAB (Dahl), 80.C.C.C. 1119 (DCA 2015) is being interpreted as requiring that a vocational analysis must be specific to the individual involved, and should not operate on the fiction that every individual has access to the entire labor market. For example, they ask that if an individual maintained consistent employment prior to an injury despite being unable to speak English, what reason is there to believe that the same handicap is causing disability after the injury?

What this ignores, however, is the fact that an individual with language barriers, or lack of an education, is already working under preinjury limitations: the so called "impermissible factors" have vastly limited applicant's access to a labor market which might otherwise be available to him had these impermissible factors not existed.

III.

APPORTIONMENT ISSUES

The seminal case with respect to establishing apportionment under the Senate Bill 899 Reform Legislation was the en banc decision in Escobedo v. Marshalls, 70 C.C.C. 604 (en banc 2005). Escobedo noted that Labor Code § 4663 now required apportionment of permanent disability to be based upon causation (referencing causation of permanent disability, not causation of injury), and that the statute required both the physicians and the Workers' Compensation Appeals Board to make determinations with respect to what percentage of permanent disability was directly caused by the industrial injury, and what percentage was caused by other factors. Applicant has the burden of establishing the percentage of his permanent disability caused by the injury, and defendant has the burden of establishing the percentage of disability caused by other factors. Permanent disability caused by other factors both before and subsequent to the industrial injury could include not only disability that could have been apportioned prior to S.B. 899, but can also include disability that formerly could not have been apportioned (such as pathology, asymptomatic prior conditions, and retroactive prophylactic work preclusions) providing that the apportionment opinion is supported by substantial medical evidence establishing that these factors cause or contribute to permanent disability.

The Supreme Court in Brodie v. Workers' Compensation Appeals Board, 72 C.C.C. 565 (2007) characterized the new version of Labor Code § 4663 as a "new approach to apportionment," which required looking at the current disability and parceling out its causative sources for the purpose of deciding the amount directly caused by the current industrial source. A panel has suggested that if a Panel Qualified Medical Evaluator is unable to render an adequate opinion on the issue of apportionment, the parties may thereafter choose an Agreed Medical Examiner (although the parties are capable of doing this at any time they wish), or the workers' compensation judge may actually appoint a regular physician for the purpose of addressing this issue. Ceuevas v. Del Monte Meat Co., 2018 Cal. Wrk. Comp. Pd Lexis 324 (2018).

Although there is some whining by the applicants' Bar with respect to apportionment conditions which were not actually causing disability prior to the industrial injury, apportionment to a prior condition that had caused no disability prior to the work related injury is proper where there is substantial medical evidence that the asymptomatic condition or pathology is now a contributing cause of the resulting disability. City of Petaluma v. WCAB, 83 C.C.C. _ (Ct. of Apl. 2018). This case also acknowledges the proposition that the apportionment must be to disability, and not to injury, although in this case the court concluded that the assessments in this case were identical.

Benson v. Workers' Compensation Appeals Board, 74 C.C.C. 113 (Ct. of Apl., 2009) addresses a subspecies of Labor Code § 4663 apportionment, that being apportionment of disability between separate and successive industrial injuries. Previously, applicants' attorneys commonly argued that successive injuries were essentially merged into a single, unapportioned disability pursuant to Wilkinson v. Workers' Compensation Appeals Board, 42 C.C.C. 406 (Sup. Ct, 1977), but at the time Wilkinson was decided, the apportionment system set forth in the Labor Code was radically different. Benson correctly determined that a system of apportionment based upon causation required that each distinct industrial injury be separately compensated based on its individual contribution to a permanent disability, although the case noted there could be limited circumstances where the evaluating physician could not parcel out the disability among injuries with reasonable medical probability. As might be expected, applicants' attorneys hung on to the comment regarding the inability to "parcel out" like grim death. Although not used by the court in Benson, the operative term these days is that the injuries are "inextricably intertwined," and thus cannot be rated separately. In Fields v. City of Cathedral City, 2013 Cal. Wrk. Comp. Pd Lexis 103, the panel found that a physician's report may constitute substantial evidence, and meet the requirement that the physician fully address the issue of apportionment, if the physician cannot parcel out these approximate percentages of causation.

There is really not much of a pattern to these cases. There was some suggestion that the occurrence of subsequent injuries before an applicant reached Maximum Medical Improvement (the old Wilkinson suggestion of successive injuries becoming Permanent and Stationary at the same time) might be a ground for saying injuries were inextricably intertwined, but this was rejected by the panel in James McClendon v. Home Test Defense (ABJ 87020502 and 8954034, Sept. 13, 2018). Another panel in Chavez v. Chief Auto Parts (ABJ 534884, May 21, 2018) found that a physician's opinion that three injuries were inextricably intertwined was not supported by substantial evidence, where the doctor did not take into consideration either the medical history or the findings of other physicians (and this case could stand for the proposition that an evaluator of a compensable consequence disability must consider the apportionment opinion of the physician evaluating the primary disability). However, it is noted that apportionment is defendant's burden of proof, and where a physician cannot parcel out non-industrial factors in specific and cumulative trauma cases, applicant is entitled to a combined, unapportioned disability award. Herrera v. Maple Leaf Foods, 46 C.W.C.R. 157 (Panel Dec., 2018). (Same result in California Insurance Guarantee Assoc. v. Workers' Compensation Appeals Board, 74 C.C.C. 1469 (Writ denied, 2009).

Escobedo, while expanding the concept of apportionment, still noted it must be supported by substantial evidence: the medical opinion must be framed in terms of reasonable medical probability, it must not be speculative, it must be based on pertinent facts and on an adequate examination and history, and it must set forth reasoning in support of its conclusions.

Herrera, actually reaches farther than one might think. It is one thing to state that the primary disability (several successive back injuries as a result of heavy lifting) caused the existence of inextricably intertwined disability, but quite another to issue a combined award for all of the primary disabilities based on the physician's statement that he cannot parcel out relatively minor consequential disability. In Herrera, for example, the primary injuries were orthopedic, and an appropriate apportionment between the orthopedic injuries was made by the Agreed Medical Examiner. However, applicant claimed gastrointestinal problems as a compensable consequence of his orthopedic injury, and it was the Agreed Medical Examiner in internal medicine (Dr. Hirsch) who stated he was unable to parcel out the internal disability as between the two injuries (it was not explained why he was unable to rely upon the orthopedic apportionment; the AME in psychiatry, Dr. Preston, reached the same conclusion with respect to consequential psychiatric disability). The Board found that where some aspects of the industrially caused permanent disability from two or more separate industrial injuries cannot be parceled out, then a combined permanent disability award must issue even though other aspects of the industrially caused permanent disability can be apportioned.

The Judge in Sami Aimad v. Galpin Ford (ABJ 2768261 and 562166, Sept. 19, 2018), tried to take this argument a step farther, but the panel held that it was a misapplication of Benson for a doctor to render an opinion that applicant's industrial disability and non-industrial disability was inextricably intertwined.

In Delao v. Workers' Compensation Appeals Board, 80 C.C.C. 287 (Writ denied, 2015) a workers' compensation judge, based upon applicant's testimony that he never recovered from a first injury, essentially found that there was only one injury causing permanent total disability, despite an Agreed Medical Examiner's report that there were two injuries. The AME had found apportionment between the two injuries, and the panel found that this was substantial medical evidence which needed to be followed.

Somewhat off the subject, but involving as it does a claim of apportionment, is Hirschberger v. Stockwell Harris, 46 C.W.C.R. 238 (2018). What the panel found was an industrial brain injury, which caused applicant to be Permanently Totally Disabled pursuant to Labor Code § 4662(a)(4), and, because these injuries are conclusively presumed to result in total industrial disability, apportionment was precluded.

What caused the brain injury was not a direct result of industrial exposure (Parkinson's disease caused the brain injury). The Parkinson's disease, although non-industrial in origin, was aggravated/accelerated by a stress injury (apparently, internal and psych) so, in actuality, what we appear to be dealing with here is a compensable consequence of a compensable consequence of an industrial injury. Since the Parkinson's disease had a non-industrial origin, it was argued apportionment should apply, but the holding was that Labor Code § 4662(a)(4) precludes apportionment in any case involving a brain injury such as this.

IV.

THIRD-PARTY CREDIT

Before addressing the meat of this subject, a couple of observations with respect to this section are necessary. We realize that this is an applicant's attorneys convention, so it is fully expected that the material presented is slanted in favor of the applicant and against the defense. However, with respect to this particular panel, the bias, and perhaps even hostility, toward the defense was palpable. When we pursue subrogation (which is really where the credit picture begins), we make every attempt to cooperate with the applicant's third-party attorney. In the appropriate case (where we recognize there is a substantial possibility of recovery and, perhaps later, credit), we actively participate with the plaintiff's attorney in the attempt to create a fund which can be used to everyone's benefit. As one of the commissioners stated during the commissioner's conference when an inquiry was made with respect to how he litigated disputes regarding Qualified Medical Examiners in his prior practice as a defense attorney, he stated he made every effort to resolve disputes in cases informally as he felt this works out best for everyone.

This particular panel took a scorched earth approach to the relationship between the injured worker and the employer, both with respect to subrogation (which was a relatively minor aspect of the panel's discussions, except to the extent that it related to setting up the employer for a fall in connection with the credit), as well as with respect to the credit itself. Thus, we have our own suggestions below for when we run into practitioners of this sort.

First, an overview. Workers' compensation is a constitutionally based no-fault system with respect to the administration of industrial injuries. Regardless of fault, an injured worker is provided with defined benefits (temporary disability, permanent disability, medical treatment, and certain types of rehabilitation services) and, in return, the employer is relieved of civil liability.

There are a couple of public policies at play here. First, assuming that someone unrelated to the employer or employee is actually responsible for the injury, the innocent employer is entitled to indemnity from the person actually responsible for the injury (sometimes known as subrogation). Even in the absence of statute, equitable indemnity would likely be available to the employer, but the legislature has seen fit to codify the employer's rights by way of Labor Code sections 3850 to 3865.

The second, intertwined public policy relates to the state's interests and attempt to prevent a person from receiving a double recovery (this being unjust enrichment), and so the statutes referenced above, in a case where a third-party is responsible for the employee's injury, attempt to balance out the relative interests of the employer and employee so that a double recovery does not occur. The two statutes focused upon by this panel were Labor Code sections 3860 and 3861, which essentially relate to prejudgment settlements of third-party cases (Labor Code sections 3856, 3857, and 3858 basically contain similar provisions, although they apply when a case actually goes to judgment, as opposed to being settled).

Review of the ground rules is appropriate: if either the employer or employee commences litigation against the third-party, Labor Code section 3853 requires service of a copy of the complaint by either personal service or certified mail on the other, with proof of service being filed in the action. This section also provides authority for intervention or consolidation of actions. Labor Code sections 3859 and 3860(a) suggest that neither the employer nor the employee can settle the claim without the consent of the other. That is not quite true. The actual intent of the statutes is to prevent either the employer or the employee from settling the case in such a way that the other is prejudiced. Essentially, the statutes require that notice of settlement be given, so that the other has the opportunity to protect their rights. The language in the statute is that the settlement or release is not "valid", and what this means is that the third-party cannot use the release against the non-settling party.

In American Home Assurance Company v. Hagadorn, 48 Cal. App. 4th 1898 (1996), it was noted that while Labor Code section 3859 allows independent settlements, it does not allow an employee to settle without notifying the employer. It notes that the purpose of the subrogation and credit statutes is to prevent a double recovery and in this particular case, there appeared to be a deliberate effort to circumvent the employer's subrogation rights. Applicant was penalized by the allowance of a credit not only in the amount of the recovery, but also in the amount of the employer's unrecovered lien.

The remainder of section 3860 (with similar provisions in section 3856) relates to who is entitled to what depending upon who was responsible for obtaining the settlement (or, in the case of section 3856, the judgment). (Employee alone, employer alone, or a joint effort). What is left after expenses and attorney's fees first goes to the workers' compensation lien, with the balance to the applicant. Section 3860(f), essentially requiring court approval for the fixing of expenses and attorney's fees is primarily observed in the breach; virtually no one follows this instruction (at least where the parties are working together). With respect to applicant's share of the third-party recovery Section 3861 relates to the credit the employer has against its liability for future workers' compensation benefits. Even though the statute suggests the credit is automatic, it is not. The employer must petition for it (or obtain a stipulation from the applicant for it), and then obtain an order. Unilateral termination of benefits upon applicant's receipt of a third-party recovery is a penalty offense. California Compensation Insurance Company v. WCAB, 66 C.C.C. 1076 (Court of Appeal, 2001). Judge Glass, one of the panelists, takes the position that petitions for credit are not walk-through items and, for the reasons noted below, he probably has a point.

Credit rights relate to applicant's net recovery, and that is what the applicant puts in his/her pocket after deduction of fees and expenses. Fees, of course, are attorney's fees, and each party is responsible for their own. Summers v. Newman, 20 Cal. 4th 1021 (1999). In this way, if one party or the other simply sits back, and allows the other to do the work, attorney's fees may be awarded from their share to the attorney who actually created the fund. This usually goes against the employer. Cases hold that the employer can even participate in the case, but if their participation does not result in the creation of the fund (settlement), the employee's attorney is still entitled to take a fee from the employer's share. Luque v. Herrera, 81 Cal. App. 4th 558 (2000). This sometimes creates difficulties for defendants as well, if they take an assignment of the employer's lien, and are then faced with an argument that, because the employer did not participate in the creation of the settlement fund, the employer's attorney should be entitled to a fee from the lien itself (although the fee is based not on the entire value of the lien, but only what is allocated to it in terms of recovery). Manriquez v. Adams, 108 Cal. App. 4th 340 (2003).

In connection with the Petition for Credit, there is really no time requirement for filing it. Pacific Gas & Electric Company v. Industrial Accident Commission, 8 Cal. App. 2d 499 (1935). The credit is against future benefits, and is not applied against workers' compensation benefits which were included in the subrogation lien; furthermore, if the employer accepted a reduction in the amount of its lien in connection with the third party settlement, that does not constitute a waiver of its right to credit. Herr v. Workers' Compensation Appeals Board, 98 Cal. App. 3d 321 (1979). In fact, an employer's waiver of its subrogation rights against the third party does not extinguish its right to a credit. Gonzalez v. Workers' Compensation Appeals Board, 77 C.C.C 452 (2012). The credit applies to all Division 4 benefits (which would include penalties, benefits as a result of serious and willful misconduct, attorney's fees, medical-legal costs, and liens). State Compensation Insurance Fund v. Workers' Compensation Appeals Board, 130 Cal. App. 3d 933 (1982). The exception is death benefits to dependents of a decedent, that were not parties and did not receive recoveries in connection with the third party litigation. Colusa Trailer v. Workers' Compensation Appeals Board, 74 C.C.C. 641 (2009).

All of this seems relatively ironclad, but it is not. The absolute rights to indemnification and credit referenced above depend upon true "innocence" of the employer. So, what happens if the innocence is not quite so pure? The seminal case on the subject is Witt v. Jackson, 57 Cal. 2d 57 (1961), decided back in the day when a little bit of contributory negligence barred the entire recovery. Basically, the idea was that the employer should not be able to take advantage of its own wrong, so if subrogation recovery was barred, third-party credit was barred as well (despite the pontification about prevention of double recoveries). With the advent of comparative negligence (Li v. Yellow Cab), things were not quite so absolute. And, eventually in connection with employer reimbursement and credit claims, the issue of employer negligence was addressed through use of the so-called Arbaugh (subrogation)/Cole (credit) formulas. They both work essentially the same, in terms of the manner in which they reduce the subrogation recovery or credit, but since we are dealing with credits here, our focus will be an Associated Construction & Engineering Company v. WCAB (Cole), 22 Cal. 3d 829 (1978). In essence, Cole requires that the percentage of employer negligence be applied to the employer's total tort damages as a result of the injury, and the resulting number represents the threshold figure at which the employer can begin claiming benefits of the credit. Thus, for example, if the employee's total tort damages equal $100,000.00, then the employer is 25% negligent, the employer's threshold is $25,000.00, before it can begin taking advantage of its credit. (The Arbaugh formula establishes the similar threshold that the lien must exceed, before that portion of the lien above the threshold becomes reimbursable, Arbaugh v. Proctor & Gamble, 80 Cal. App. 3rd 500 (1978)).

Employer negligence is generally always an issue where the employer exercised some degree of control of the instrumentality or premises on which an employee is injured. Machine cases generally present the biggest problems because of the possibility of tampering or modification by the employer, but the Panel points out there are opportunities to find employer negligence virtually everywhere based upon the employer's legal duty to maintain a safe and healthful place of employment pursuant to the mandate of the Labor Code, a duty which is greater than the duty of care imposed pursuant to common law principles, and a duty which encompasses many responsibilities, including the duty to inspect the workplace for the purpose of discovering and correcting dangerous conditions, and giving adequate warning of its existence. Bonner v. WCAB, 225 Cal. App. 3d 1023 (1990). This includes the doctrine of "corporate negligence", where an employer can be found negligent with respect to the activities of an independent contractor on its premises. Elam v. College Park Hospital, 132 Cal. App. 3d 332 (1982).

Now, with respect to the Panel, the entire message was to force the employer to abandon its lien in the Superior Court, and then, using the Plaintiff's experts in the Superior Court (to establish causation and the percentage of negligence) and Plaintiff's attorney (for the purpose of establishing total tort damages, which will likely be in excess of the settlement amount), attempting to establish a threshold so high that the employer would never be able to take advantage of its credit. Coupled with this will be Petitions for Costs under Labor Code §5811 for the attorney's time in testifying (figuring this will keep the cross-examination brief) and the experts (for their time in preparing appropriate declarations and/or testifying). From the employee's standpoint, this makes the credit issue so expensive for the employer that the employer will likely just give up.

This starts, of course, with a "settle around" in the third party action. The position being advocated appears to be settling around the Employer/Carrier possibly with an agreement to hold the Defendant harmless against the workers' compensation lien (thus, the settlement would have to be enough money to cover the lien). The Plaintiff's attorney on the Panel tells us what he does is demand that the employer withdraw its subrogation lien, or he will try the Defendant's case against them (actually, that is backwards from the way it works; the employer steps into the Plaintiff's shoes, and tries the case against the Defendant, who is now being defended by Plaintiff's attorney). The Panel tells us that with all the third party evidence already developed, it just shifts the presentation of all that evidence to the Workers' Compensation Appeals Board after the employer walks away from the civil litigation.

Certainly, there are times to walk away. If the employer has a machine where the guard has been removed, that is a fairly hopeless subrogation and/or credit case, so if the Defendant does not pay you any money, you walk away. On the other hand, if you have a debatable case (no guard removals, no OSHA violations, nothing overt which suggests negligence), then the best idea, we think, is to try the third party case in the Superior Court and go to verdict. We say this because we think that the employer will fare better in the Superior Court than at the Workers' Compensation Appeals Board (where the employee gets the benefit of the doubt). Furthermore, the expenses of doing this might actually be less.

We will know fairly early on, perhaps, who we are dealing with in terms of a Plaintiff's attorney. If the attorney is unwilling to share an expert, we can probably reasonably reach a conclusion that he is going to be hostile to the employer. If that is true, then the employer needs to retain its own experts and, thus be ready to try the Superior Court case on its own, if need be. The Superior Court action will determine the issue of negligence, as well as Applicant's total tort damages.

As long as the employer is prepared for the Superior Court trial, we think this course of action would bring a better result than attempting to litigate the employer negligence issue, as well as the issue of Applicant's total tort damages, before the WCAB.

V.

MEDICARE SET-ASIDES

Quite frankly, we fail to understand the insistence of some of these Panelists that applicant's attorneys need to drive up the cost of the Medicare Set-Asides based on the argument that Defendants are under valuing them, other than to increase the potential fund for an attorney's fees (one of the Panelists actually mentioned that). If the Medicare Set-Aside allocation is approved by CMS, that is a certification that it is adequate and applicant's Medicare benefits are protected even after the MSA is exhausted. The accusation of some of the Panelist that Defendants are illegally attempting to transfer responsibility for industrial medical treatment onto Medicare by way of these MSA's is unfair and false. Defendants have every right to insist that they not be charged for anything more than that for which they are actually and practically responsible. Defendants have every right to negotiate with CMS with respect to this responsibility, and that is what is accomplished through the MSA process.

The basis for these claims is the underlying theme of this session, that being the proposition that if a Defendant prepares a proposed MSA, they desperately want to settle, and will pay a lot of money to do it. There may be circumstances where that is true; in many cases, it is not.

By way of review, there are no statutory or regulatory provisions requiring that the parties submit a workers' compensation Medicare Set-Aside proposal to CMS for review. However, if a proposed Medicare Set-Aside meets the work load review thresholds for CMS, and CMS reviews and approves the Medicare Set-Aside amount and the account is later appropriately exhausted, Medicare will pay Medicare covered workers' compensation related medical bills for services otherwise covered and reimbursable by Medicare. If the parties to a workers' compensation settlement stipulate to the Medicare Set-Aside amount, but do not receive CMS approval, then CMS is not bound by the set-aside amount stipulated by the parties (although it might also be in agreement). If CMS does not believe the stipulated amount to be adequate, it may refuse to pay for future medical expenses related to the industrial injury.

If a person is on Social Security Disability, a reasonable Medicare Set-Aside allocation is required with respect to every settlement, although it will not necessarily be reviewable by CMS. CMS's review thresholds are as follows:

1. The claimant is a Medicare beneficiary, and the total settlement amount is greater than $25,000.00; or

2. The claimant has a reasonable expectation of Medicare enrollment within 30 months of the settlement date, and the anticipated total settlement amount is greater than $250,000.00. The claimant has a reasonable expectation of Medicare enrollment within 30 months if any of the following apply:

    (a) The claimant has applied for Social Security Disability benefits, been denied Social Security Disability benefits but anticipates appealing, or is in the process of appealing and/or refiling for Social Security Disability benefits;

    (b) The claimant is 62 years and 6 months old;

    (c) Claimant has end stage renal disease.

These thresholds are pursuant to the CMS letter guideline of May 11, 2011.

In the event CMS review takes place, and if CMS makes a determination of a different amount than that originally proposed, there is no formal appeal process. Additional documentation may be submitted for the workers' compensation review contractor to justify the original proposal. A request for a rereview may also be submitted based upon the existence of mathematical error, and CMS does permit a one time request for a rereview where a prior approval was issued at least 12 but no more than 48 months prior, the case has not yet settled, and projected care has significantly changed (at least 10% or $10,000.00, which ever is greater). If a proposed MSA has been closed by CMS for inactivity for over a year, a resubmission is necessary.

We do have clients who propose "CMS waivers" in connection with Compromise and Release offers. These settlement offers involve a professionally prepared Medicare Set-Aside allocation document, but it is simply stipulated as being a reasonable amount to satisfy Medicare's interest by the parties, without formal CMS approval. The Panelists strenuously advise that these should be rejected, as they carry too much risk to the applicant. The exception to this recommendation is where the MSA is professionally administered and guaranteed by the vendor (the vendor interacts with Medicare where necessary, and will cover the costs of medical services if CMS rejects the estimate).

In most cases, the Panelists advise that the MSA should be professionally administered

In terms of calculating the true amount of a Compromise and Release, the Panelists note that there are numerous non covered items, including deductibles, co-payments, and the cost of supplemental insurance.

In order to settle these types of claims, both sides need to be reasonable. CMS approval protects applicant's interests. Thus, in most cases, while we have no problem with applicant's attorneys following the MSA process and reviewing the documents as they are completed, there is no reason for them to become involved in the CMS approval process.

VI.

MISCELLANEOUS

A very significant case which many of us have been watching is *King v. Comp Partners* 83 C. C.C. 1523 (Supreme Court, 2018) in which an applicant sued a utilization reviewer for medical malpractice in connection with a Utilization Review Decision which had the effect of terminating his access to medication without weaning. This sudden withdrawal resulted in seizures. The Supreme Court held that the utilization reviewer is immune from tort liability based on negligence or failure to warn of potentially injurious consequences of discontinuing medication. This is because the Utilization Review process is part and parcel of the claims process, and, because of this, the Exclusive Remedy Rule applies which bars a separate negligence action.

In connection with Utilization Review, there are a couple of exceptions which are being carved out. First, in *Alvarado v. Warner Brothers*, 46 C.W.C.R. 119 (Panel Decision, 2018), a Findings and Award had issued in applicant's favor finding that he was in need of future medical treatment with respect to orthopedic, cardiac, diabetes, and psyche. Following the issuance of the Findings and Award, applicant requested the carrier to provide him with secondary treaters in the field of cardiology, orthopedics, and psychiatry, and the carrier refused, taking the position that such a referral required a Request for Authorization and Utilization Review.

The Workers' Compensation Appeals Board disagreed, holding that neither an RFA nor UR is required for an authorization for a secondary treating physician, since there was no specific request for medical treatment, simply an authorization to see the treaters. Once the secondary treater makes a recommendation for a specific treatment, then the RFA and UR process is invoked.

There is a trap for Defendants in *Reyes v. North Ridge*, 2018 Cal Work Comp P.D. Lexis 133, which essentially holds that a Defendant has a regulatory duty to conduct a reasonable and good faith investigation to determine whether benefits are due, citing Labor Code §4600 and Regulation 10109. This related to medical treatment, wherein two treating physicians rendered an opinion that applicant was 100% Totally Disabled, and was in need of home healthcare services. It does not appear that the carrier took any action with respect to this, and ended up in an Expedited Hearing in connection with which ongoing home healthcare services were ordered (and the Panel affirmed this). The fact that the recommendation was in the report created an obligation for the Defendant to investigate (the Panel citing the *en banc* decision of *Neri Hernandez v. Geneva*, 79 C.C.C. 682 (2014), as well as *Braewood v. WCAB*, 44 C.C.C. 566 (1983).

It seems in this case that the two physicians involved were actually treating physicians so why a RFA was not submitted is unclear. However, the thrust of the Panel's position is that since a significant need was identified in the medical report, the Defendant then had an obligation to investigate it, and take appropriate action with respect to it (potentially, the report itself could have been submitted to Utilization Review).

Suon v. California Dairy, 83 C.C.C. 1803 (en banc, 2018) dealt with communications with the Panel Qualified Medical Examiner. This was primarily a cardiac stress case, in which the internal medicine QME found applicant's heart condition non industrial but, at his deposition, applicant's attorney inquired whether he was interested in reviewing the psychiatric QME report (which had not yet issued) regarding stressful activities, with the internist advising that he would be.

When the psychiatric report issued, defense counsel sent a copy of it to the internist, with a cover letter which apparently just referenced a "CC" to applicant's attorney, who claimed he never got the letter (the internist reviewed the psychiatric report, and did not change his mind). It was upon receiving this report that applicant's attorney complained he had not received the communication to the internist, which was really nothing more than a forwarding letter. Applicant's attorney moved to disqualify the internist on the ground of an ex parte communication, and the Board noted two problems:

1. If in fact an ex parte communication had taken place, the automatic remedy was disqualification of the doctor, but this was actually disputed by Defendant who indicated he had sent a copy to applicant's attorney. It certainly appears to us that there was no willful ex parte communication. As a practical matter, the complaint would actually appear to be somewhat specious, when it was applicant's attorney who suggested initially that the report be sent to the doctor, who requested it.

2. There was a violation of Labor Code §4062.3(b), which requires 20 day notice before material is sent to a Panel QME. However, there is a balancing test involved which explores whether or not there was prejudice, the relevance of the material, and case specific reasons for retaining or discarding the QME.

Finally *Wachiuri v. Torrance Memorial Medical Center*, 83 C.C.C. 1494 (Panel Decision, 2018) stands for the proposition that, in connection with an AOE/COE PQME evaluation, the Defendant is entitled to tell the PQME whether or not the claim is denied, and any reasons for denial of the claim which would be relevant to the medical issues to be considered by the doctor. Thus, the defense that the claim was brought post termination was irrelevant to the medical issues to be considered by the doctor, and thus could not be sent.

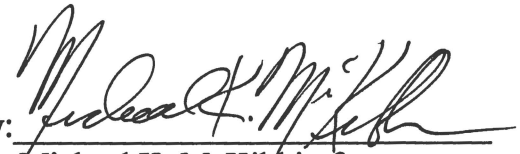
VII.

CONCLUSION

For the most part, workers' compensation, even in connection with the litigated cases in which law firms from both sides are involved, requires that the parties be reasonable and practical. We once heard an applicant's attorney remark after one of these conventions that if he did everything the Panelists were suggesting he do, he would go bankrupt because he would never be able to resolve his cases. Most certainly, while from an applicant's attorney's standpoint, it might be worthwhile to put some of these ideas into practice with respect to a particular case, all of us should be primarily focused on getting these cases in and out of the system as expeditiously as possible. That is the purpose of the workers' compensation law, and for most applicants, that is probably in their best interests as well.

If you have any questions, or feel that continuing education with respect to these or any other issues would be worthwhile, we would be more than happy to assist.

Very truly yours,

By: 

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