

Case Law Update Nov 2010 – Nov 2011

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I

JURISDICTION, CONSTITUTIONAL MANDATE OF PLENARY POWER TO CREATE A WORKERS' COMPENSATION SYSTEM

Carroll v. Louisiana Workers Compensation Corp., (2010) 38 CWCR 176 (WCAB Panel) (Jurisdiction – out of state employment.)

The Workers' Compensation Appeals Board has reversed a WCJ's award of compensation to a out-of-state professional football player who claimed that playing in three games in

California contributed to his cumulative injury to multiple parts of his body. The Workers' Compensation Appeals Board indicated that a non-resident employee hired out of state is exempted from California Compensation laws while temporarily in California if the conditions specified in Labor Code §3500.5(b) have been met.

Labor Code §3600 5 (b) provides that an employee who has been hired outside California is exempted from California Workers Compensation provisions while temporarily in California if (1) the employer has furnished Workers' Compensation insurance coverage under the workers' compensation laws of another state that covers the employee's employment while in this state, (2) the extraterritorial provisions of California Law are recognized in the other state, (3) employees and employers covered in California are likewise exempt from the application of the workers compensation laws of the other state. The benefits under the workers compensation laws of the other state are the exclusive remedy against the employer for any injury received by the employee while working for the employer in this state. The code section goes on to state that a certificate from the duly authorized officer of the appeals board or similar department in the other state certifying the out-of-state employer has coverage insuring employees are covered working within this state shall be prima facie evidence that such employer has coverage. Because the evidence concerning these criteria had been incomplete, further evidence was necessary and the matter was therefore remanded to the trial level.

Bautista et al. v. State of California et al., (2011) ___ Cal. App. 4th ____ (Court of Appeal, 2nd Appellate District) (Plenary power to create a workers' compensation system does not create an affirmative duty for specific provisions or benefits.)

Bautista et. al., were individual farm workers and the United Farm Workers of America who sought declaratory and injunctive relief by suit against the State, DIR, and the Standards Board, for allegedly failing to comply with the constitutional duty under Article XIV, Section 4 of the California Constitution.. The complaint alleged the current heat illness prevention regulation (Cal. Code Regs., tit. 8, § 3395, promulgated by the Standards Board, did not ensure the safety of farm workers from heat-related illnesses. Appellants' claim was dismissed by the Superior Court.

The Court of Appeal affirmed the judgment of dismissal, determining that appellants did not state a cause of action for a violation of article XIV, section 4. The Court concluded that Article XIV, Section 4 was not "self-executing," i.e., that it was not "so complete with respect to the nature of the right and the means to enforce it that no further action by the Legislature is necessary," as was claimed by the appellants.

"Rather, the constitutional provision directs the Legislature to create and enact, through appropriate legislation, a complete system of workers' compensation, which includes

enacting safety laws.” The Court also concluded that appellants’ “request for declaratory and injunctive relief violated the separation of powers doctrine as appellants ask this court to divest the legislative and executive branch of discretion to promulgate and enforce safety and health regulations.”

The Court rejected appellants contention that based on the language of Article XIV, section 4, implementing legislation is unnecessary to give effect to the constitutional right of securing safety in places of employment, holding that “neither the plain language of the constitutional provision nor the legislative history supports appellants’ construction of article XIV, section 4.”

The Court determined that Article XIV, section 4 expresses a clear intent that implementing legislation is necessary to give effect to this constitutional right; that Article XIV, that section 4 states broad principles, not enforceable rules; and that the legislative history confirms that legislative action is necessary to implement the broad rights described in Article XIV, section 4. The Court concluded, among other things:

“To the extent that article XIV, section 4 states a public policy, it does not create an affirmative duty on the part of the state. (See *Clousing v. San Francisco Unified School Dist.* (1990) 221 Cal.App.3d 1224, 1236-1237.) A public policy statement “ ‘ ‘ ‘ ‘ ‘merely indicates principles, without laying down rules by means of which those principles may be given the force of law.’ ” ” ” (*Id.* at p. 1237.) The right proclaimed in article XIV, section 4 establishes the principles and the specific means to achieve those principles is left to the Legislature.”

EMPLOYMENT

County of Kern v. Workers’ Compensation Appeals Board (Petersen), (2011) ___ Cal. App. 4th ___; 76 Cal. Comp. Cases 1037; 39 C.W.C.R. 231 (Court of Appeal, certified for publication 10/31/2011). (County’ support of Volunteer Fire Department renders its members County employees.)

Eric Petersen was the Deputy Fire Chief of the Sand Canyon Volunteer Fire Department (SCVFD). SCVFD, the only remaining volunteer fire department in Kern County, is comprised of approximately 32 unpaid firefighters who actively protect the 21-square-mile unincorporated Sand Canyon area within eastern Kern County between Tehachapi and Lake Isabella. SCVFD submits to recertification from the state with Kern’s assistance every two years, and trains its chief and members as mandated by the state and Kern. According to SCVFD Chief William Bender, Kern supplied SCVFD with thousands of dollars worth of fire equipment in the late 1990’s. Kern also installed a dip tank to supply water both to a KCFD helicopter and to the SCVFD’s fire station. Petersen filed two workers’ compensation claims alleging he injured his right ankle stepping off a fire truck on 11/1/07, and his head during an

assault while responding to a call for assistance on 7/16/08. Petersen was 71 years of age at the time of his first alleged injury and 72 years of age at the time of the second. In correspondence prior to the claims and in the cases, County of Kern disputed employment and liability for workers compensation benefits. Labor Code §3361 provides:

"Each member registered as an active firefighting member of any regularly organized volunteer fire department, having official recognition, and full or partial support of the government of the county, city, town, or district in which the volunteer fire department is located, is an employee of that county, city, town, or district for the purposes of this division, and is entitled to receive compensation from the county, city, town or district in accordance with the provisions thereof."

The WJ found that under Labor Code §3361, County of Kern was the employer liable for compensation benefits for Peterson's injuries. Defendant sought reconsideration.

The WCAB sustained the WCJ's findings of employment. Applicant was a registered active firefighting member of a regularly organized volunteer fire department having official recognition and full or partial support of the government of petitioner, Kern County. Defendant filed a Petition for Writ of Review.

The Court of Appeal granted review and affirmed the Workers' Compensation Appeals Board's holding that Kern is the statutory employer. It rejected Kern's argument that it never provided the organization with either the "official recognition" or "full or partial support" required under Labor Code §3361 to invoke its workers' compensation liability, as "more burdensome than set forth under the plain language of the statute." As the issue was not yet addressed by the WCAB, the Court made "no determination as to whether the volunteer firefighter was industrially injured or if County of Kern had effectively limited its coverage responsibility through its contractual agreement with the volunteer firefighters organization.

INSURANCE, INSURANCE COVERAGE, CALIFORNIA INSURANCE GUARANTEE ASSOCIATION:

INJURY ARISING OUT OF AND OCCURRING IN THE COURSE OF EMPLOYMENT, COMPENSABILITY THRESHHOLD FOR PSYCH INJURIES:

Herndon v. City of Pasadena, (2011) 39 C.W.C.R. 11 (WCAB Panel decision) (Going and Coming Rule.)

Applicant was employed⁵ by the City of Pasadena. The City maintained two parking lots near the offices where the applicant worked. (Mountain and Sunset) On December 31, 2009 when the applicant arrived at work both parking lots were full, she parked on the street next to

a curb where a co-employee also parked. A security guard told her she could not park at that location because of the Rose Parade. She left her car anyway and went to her office. Applicant was asked by a co-employee go to move their car so she went and moved the car to the Mountain Lot, and while crossing the street returning to work she was hit by a truck. The WCJ found that applicant's injury was not industrial because (1) parking was available in the lot in front of the guard shack, (2) parking was available in the Sunset lot, and (3) private employee parking was not allowed inside the gate. Applicant filed a petition for reconsideration.

The Workers' Compensation Appeals Board found that the applicant was injured crossing the street from an employer-provided parking lot to her work place. Because the parking lot was part of the employers premises applicant was no longer in her commute and had arrived at work. The going and coming rule did not apply and because the injury occurred within a reasonable margin of time and space necessary for her to pass from the parking lot to work she was on the employers premises. The WCAB rejected the conclusions of the WCJ that the applicant had abandoned her employment when she left the building without permission to move her illegally parked car. The WCJ had cited no legal authority to support that conclusion. The fact the applicant left the building to mover her illegally parked car was not determinative. Moreover the injury occurred when the applicant was leaving the employer provided parking lot. Although there was testimony form a defense witness that the applicant needed permission to leave the building, there was no evidence that leaving the building for a few minutes was strictly prohibited. The Workers' Compensation Appeals Board granted reconsideration and found applicant's injury arose out of and occurred in the course of her employment.

Reff v. Meadowbrook Ins., (2011) 39 C.W.C.R. 211 (WCAB Panel) ((Medical opinion evidence of cause of injury; possible temporary aggravation not supporting award of future medical treatment.)

Applicant filed an application for an injury consisting of pneumonia affecting her persisting asthma and CVID while employed as a nurse. Defendants denied liability but agreed to Edward O'Neill as a QME. Dr. O'Neill found the pneumonia industrial but that the question of the CVID, which he described as a rare and unusual condition, required a consultation. After the consultation O'Neill wrote that there was no clear precedent in the literature to support treatment for CIVD on an industrial basis because the immune deficiency is primarily a genetic disorder. He further concluded that the need for Vivaglobin infusions was industrially related because applicant did not require them before having pneumonia as a result of an industrial injury. At his deposition when asked if the pneumonia caused, aggravated or contributed to the CVID he indicated before he could give an opinion he would need to review the CVID test results between 2004 and 2007. Following a hearing the WCJ found that the

applicant sustained an industrial injury resulting in pneumonia and, as a consequence thereof, the pneumonia had adversely affected applicant's CVID and had significantly contributed to applicant's continuing need for immunoglobulin deficiency treatment. The defendants filed a petition for reconsideration.

The Workers' Compensation Appeals Board granted the petition for reconsideration, and the matter was remanded because the AME had not resolved the issue of causation of the CVID; he never reviewed the blood test results. The parties obtained further medical evidence. Applicant's treating immunologist wrote that although the pneumonia may have caused a mild transient reduction in applicant's IgG or IgG-subclass levels the effect would have not been permanent. He found no permanent lung damage as a result of the pneumonia. The AME conceded that it was logical for the treating immunologist to conclude that the reason that the doctors continuing the immunoglobulin therapy was to treat the underlying nonindustrial CVID. Asked whether it was medically probable that the applicant was being treated with immunoglobulin solely for the natural progression of the underlying non-industrial CVID condition the AME indicated medically probably yes. Following another hearing and the admission into evidence of all the additional medical evidence the WCJ found that sustained an industrial injury resulting in the contraction of industrial pneumonia and as a consequence thereof adversely (affecting) applicant's pre-existing and dormant CVID and triggering the need for immunoglobulin deficiency replacement treatments. The WCJ awarded future medical at defendant's expense. Defendants filed another petition for reconsideration.

The WCAB granted reconsideration and reversed the WCJ. The Board indicated that the award of medical treatment was not justified based on the medical record. The WCAB indicated that whether disability resulted whole or in part the normal progression of a non-industrial pre-existing condition or from a fully compensable lighting up or aggravation of a pre-existing condition is a factual issue. The determination will not be annulled if it is based on substantial evidence. The panel recognized that required medical treatment independent of an industrial injury or condition is not an employer's responsibility. Here the opinions of the treating physician and the AME established that applicant's pneumonia was industrially contracted, but the preponderance of the medical evidence was that the applicant only suffered a temporary aggravation or lighting up of her pre-existing CVID condition. There was no basis to award medical treatment for the CVID. The WCAB found that the pneumonia was compensable but it had not aggravated applicant's pre-existing CVID and applicant was not in need of further medical treatment to cure or relieve from the effects of the injury.

San Francisco Unified School District v. Workers' Compensation Appeals Board (Cardozo), (2010) 190 Cal. App. 4th 1, 75 Cal. Comp. Cases 1251. (Injury AOE-COE – Psyche – good faith personnel action exception.)

Linda Cardozo suffered a psychiatric injury caused predominately by actual events of employment. The WCJ found that Cardozo's injury was caused 15 percent by nonindustrial causes, and 85% by actual events of employment. Of the actual events of employment causing injury, 51% resulted from her activities as a classroom teacher, and 34% was caused by lawful, nondiscriminatory, good faith personnel actions. The WCJ therefore concluded that Cardozo's claim for compensation was not barred by Labor Code §3208.3(h) after finding that lawful, nondiscriminatory, good faith personnel actions constituted less than 35 percent of all industrial and nonindustrial causes of her psychiatric injury. Therefore, the good faith personnel actions were not a substantial cause overall of her psychiatric injury. Defendant sought reconsideration.

The WCJ reported that resolving District's challenge required a determination whether the calculation of "substantial cause" should be limited to a consideration of only the industrial causes or should include consideration of the 15 percent apportioned to nonindustrial causes. The WCJ concluded that when read together, the plain meaning of §3208.3(b)(3) and §3208.3(h) is that "all causes," whether industrial or not, must be taken into account in determining whether or not a psychiatric injury was substantially caused by 'good faith personnel actions.' The WCJ also concluded that this interpretation is not inconsistent with the Legislature's stated intent of reducing psychiatric injury claims. "§3208.3(b)(1)'s requirements that actual events of employment be involved, as opposed to generalized concerns about the financial stability of the employer . . . , and that those events were the predominant cause of the injury, are not disturbed." The Workers' Compensation Appeals Board adopted and incorporated the WCJ's decision denying reconsideration.

Defendant filed a Petition for Writ of Review contending that the WCJ & WCAB should only have considered the total of the industrial causes and disregarded the nonindustrial causes when calculating the percentage of the psychiatric injury attributable to good faith personnel actions. If this argument were correct, it would require a recalculation, leading to a denial of compensation to Cardozo under §3208.3(b)(3) and §3208.3(h). The court rejected the District's argument and affirmed. It held:

"When a psychiatric injury is alleged and the 'good faith personnel action' defense has been raised, the ALJ must evaluate the Labor Code §3208.3(h) defense according to a multi-level analysis. First, the ALJ must determine whether the alleged psychiatric injury involves actual events of employment and, if so, whether competent medical evidence establishes the required percentage of industrial causation. If these first two conditions are met, the ALJ must then decide whether any of the actual employment events were personnel actions. If so, the ALJ must next determine whether the personnel action or actions were lawful, nondiscriminatory, and made in good faith. Finally, if all these criteria are met, competent medical evidence is necessary as to causation; that is, whether or not the lawful, nondiscriminatory, good faith personnel action or actions are a substantial cause, accounting for at least 35 to 40 percent of the overall psychiatric injury as defined by

Labor Code §3208.3(b)(3). (*Rolda v. Pitney Bowes, Inc.* (2001) 66 Cal. Comp. Cases 241, at 245-247; 1 Hanna, Cal. Law of Employee Injuries and Workers' Compensation (rev. 2d ed. 2008) §4 .69[3][d], p. 4-100.)”

The Court then rejected defendant’s argument that the substantial cause calculation contained in Labor Code §3208.3(h) should not be interpreted to include nonindustrial causes, and that Dr. Baumbacher’s opinion that 40 percent of applicant’s psychiatric injury was due to good faith personnel actions should have barred her claim under Labor Code §3208.3(h). The Court stated:

“The plain language of Labor Code §3208.3 is determinative. §3208.3(b)(3) directs us to consider ‘all sources combined’ in calculating the percentage of psychiatric injury caused by good faith personnel actions. ‘All sources combined’ can only reasonably be interpreted to mean industrial and nonindustrial sources. In addition, as we noted above, the similar phrase ‘all causes combined’ in §3208.3(b)(1) has been interpreted to mean ‘the entire set of causal factors.’ (See, *Department of Corrections v. Workers’ Compensation Appeals Board (Garcia)*, (1999) 76 Cal. App. 4th at p. 816; 64 Cal. Comp. Cases 1356.) Clearly, the entire set of causal factors includes the industrial and nonindustrial causes of the psychiatric injury. Thus, on its face, the statute contradicts District’s argument that nonindustrial sources of an employee’s injury should be excluded when determining whether the psychiatric injury was substantially caused by a good faith personnel action.

“District argues that Labor Code §3208.3(b)(3) applies only to subdivision (b), but, again, the plain language of Labor Code §3208.3(b)(3) undermines District’s position. It defines ‘“substantial cause” ‘ [f]or purpose of the *section* . . . ,’ which includes Labor Code §3208.3(h). (Italics added [by the Court].)”

The Court also rejected defendant’s contention that this interpretation of §3208.3(h) is inconsistent with the statutory intent, set out in the statute when it was first adopted in 1989, “to establish a new and higher threshold of compensability for psychiatric injury.” The Court stated:

“§§ 3208.3(b)(2), 3208.3(b)(3) and 3208.3(h) were enacted together in 1993. On balance, these subdivisions favored employers, but each separate piece of the legislation did not. . . . Thus, Labor Code §3208.3(b)(2) ‘creates a slightly more employee-favorable rule for claims arising out of violent occurrences.’ (*Wal-Mart Stores, Inc. v. Workers’ Compensation Appeals Board*, (2003) 112 Cal. App.4th 1435, 1440, fn. 7.) Newly enacted §3208.3(b)(1) elevated the level of industrial causation of a psychiatric injury from 10 percent of all causes to ‘predominant as to all causes,’ and § 3208.3(h) added the good faith personnel action defense. But the legislative package also limited this defense by providing that it applied only where the personnel action ‘substantially caused’ the psychiatric injury. We decline District’s invitation to ignore the plain language defining ‘substantial cause’ and impose a definition the Legislature could have [chosen] but did not choose.”

Finally, the Court concluded “that, when read together, the plain meaning of Labor Code §§3208.3(b)(3) and 3208.3(h) is that the entire set of industrial and nonindustrial causal factors must be taken into consideration in determining whether or not a psychiatric injury was substantially caused by “good faith personnel actions.”

County of Los Angeles v. Workers’ Compensation Appeals Board (Reed), (2011) 76 Cal. Comp. Cases 806 (Writ Denied) (Causation of injury to the psyche differs from apportionment, including apportionment of conditions causing injury to the psyche.)

Applicant sustained admitted industrial injuries to her hands, wrists, and hypertension. She also claimed injury to her back and Psych. Applicant attended three AME exams in psych, internal medicine and orthopedics. The case went to trial and applicant presented the testimony of a VR counselor. Following trial the WCJ found that applicant was entitled 100% PD without apportionment. Defendant filed a petition for reconsideration.

The WCAB upheld the decision of the WCJ. As to the psych injury and the issue of predominant cause the WCAB indicated the AME in reviewing the medical records that the applicant had nervousness going back to 1984. The AME found a further history of a mastectomy in 1985 though it was likely the stress related to the cancer diagnosis dissipated. Her mother died in the mid-1990s. She became increasingly depressed and anxious over the loss of function of her upper extremity and low back problems. Overall the AME found that the predominant cause of applicant’s onset of depression, and her pain disorder was a reaction to the industrial injury, including the chronic pain and the loss of function she experienced. The AME apportioned the psych disability 29% to pre-existing anxiety, 30% to her non-industrial reaction to the reoccurrence of breast cancer and 50% to the reaction to her pain and loss of function caused by her orthopedic condition. The AME concluded that because there is apportionment of the orthopedic injury to non-industrial causes less than 50% of her psych injury was caused by industrial factors. The WCAB indicated that the issue of apportionment pursuant to Labor Code §§4663 and 4664 and causation of psych injuries pursuant to Labor Code §3208.3 are not identical. In the significant panel decision of *Reyes*, 70 Cal. Comp. Cases 223, it was held that the amendments to Labor Code §§4664 and 4664, which govern apportionment issues have not affected the statutes governing the determination of injury AOE-COE pursuant to Labor Code §§3600 and 3208.3 or the case law interpreting those statutes. In this case the AME found that although apportionment of less than 50% of the psych PD was to the industrial injury the AME found that the predominant cause of the psych injury was the industrial injury. Therefore the WCAB found the psych injury compensable. The WCAB further found there was substantial evidence based on the AME reports and depositions and the testimony of the vocational expert to support the finding of 100% PD. The WCAB in coming to this conclusion cited the cases of *LeBeouf* (48 Cal. Comp. Cases 587) and *Gill* 50 Cal.

Comp. Cases 258). The WCAB further indicated they were not required to obtain a recommended rating for the DEU in order to reach that conclusion citing *Blackledge* (75 Cal. Comp. Cases 613) The writ of review was denied.

Hamilton v. Workers' Compensation Appeals Board, (2011) 76 Cal. Comp. Cases 817 (Writ denied) (Six month employment requirement for compensability of psychiatric injury)

Applicant filed an application for injury to her Psyche in the form of a CT beginning 9/08 to present and continuing. Defendant denied injury claiming the case was barred pursuant to Labor Code §3208.39d) the six-employment rule. The matter was tried on that issue. The evidence established the applicant completed an on-line employment application on 8/6/08. She completed a new hire form on 8.20/08. Applicant was kept on the company books until 1/25/10, since defendant kept her position open for her. The applicant completed her w-4 and received an employment handbook on 8/20/08. Her first day of work was 9/15/08. Her official hire date was Sunday 9/14/08 but she began earning wages on Monday 9/15/08. She worked continuously until 3/12/09. She stopped earning wages on 3/12/09. After 3/12/09 and through 1/25/10 her employer paid for her health insurance including the employee's share of the premium, but she had no earnings. Prior to starting paid employment the applicant on her own time and own expense went to an office in LA to pick up a lap top computer that she needed for the training program. The applicant was not remunerated in any way for picking up the lap top. If the applicant first day of work was 9/15/08 and her last day of work was 3/12/09 the applicant would have worked 5 months and 26 days. The WCJ found the case was not barred by Labor Code §3208.3(d) even though it was not caused by a sudden and extraordinary event because the WCJ counted the time the applicant was on the books and therefore was employed over 6 months. Defendants filed a petition for reconsideration.

The WCAB found that the applicant did work for a period of close to 6 months but she did not work the required 6 months. Applicant was only paid for 5 months and 26 days. The WCAB rejected applicant's argument she was employed beginning 9/12/08 the day she picked up the lap top computer for training as she was not remunerated for that day, therefore that day does not count as providing actual service to the employer. The WCAB further found that the fact the employer kept her on the books and paid her health insurance did not count as days of employment as there was no actual services performed for the employer. The WCAB found the applicant had not met the 6 month requirement pursuant to Labor Code §3208.3 and therefore the WCAB reversed the WCJ and made a finding the statute requires six months of actual performance of services to the employer to meet the threshold. Applicant filed a writ which was denied.

DISCOVERY:

Vargas v. Select Staffing, (2011) 39 C.W.C.R. 14 (WCAB Panel) (Effect of asserting privilege against self incrimination)

Applicant filed an application for a CT injury to several body parts. Defendants denied injury and set applicant's deposition. At the deposition defendant asked applicant questions about her possession of a California driver's license, her use of other names, social security numbers and dates of birth. Applicant asserted her constitutional privilege against self-incrimination and based on that assertion applicant refused to answer the questions. Defendants' petitioned for an order suspending action and barring benefits. Applicant filed a petition for costs, sanctions and attorney fees. The matter was set for hearing and the WCJ following that hearing denied both petitions. The WCJ denied defendants petition because the applicant did not fail or refuse or to submit to a medical examination. Defendant filed a Petition for Reconsideration.

The Workers' Compensation Appeals Board granted reconsideration and pointed out that defendants' petition was based on Labor Code §5710(a) which covers depositions of witnesses. The board cited four cases holding that the privilege against self-incrimination is waived as to matter that are directly relevant to litigation commenced by the holder of the privilege. (*Powers v. Workers' Compensation Appeals Board*, 44 Cal. Comp. Cases 906 W/D; *Britt v. Workers' Compensation Appeals Board*, 20 Cal. 3d 844, *Shepherd v. Workers' Compensation Appeals Board*, 17 Cal 3d 107 and *Newson v. Workers' Compensation Appeals Board*, 37 Cal. App. 3d 1050.) The Workers' Compensation Appeals Board stated that in *Newson* the Court of Appeal affirmed a trial judge who ruled that Newson had a choice to answer the questions (about filling a tax return) or withdrawing his claim for earnings and could not have his cake and eat it too. Defendants did not dispute that as, as stated in *Cramer v. Tyars*, 23 Cal. 3d 131, a witness has the right in any proceeding to decline to answer questions that may be incriminating. The Workers' Compensation Appeals Board lacks power to order applicant to testify in contravention of her constitutional rights, however in this case defendants needed answers to its questions in order to assess their potential liability. The panel agreed it could not order the applicant to testify in violation of her privilege of self-incrimination. Equally compelling constitutional guarantees prohibit the Workers' Compensation Appeals Board from awarding benefits without according the defendants' rights to cross-examine the applicant, present rebuttal evidence, and defending against a claim that applicant was attempting to hide behind a cloak of privilege. As explained in *Newson* the applicant could answer all relevant questions or she could withdraw her claim. Ideally the parties would resolve the matter between themselves. If they cannot it was the responsibility of the WCJ to determine which questions posed by defendants were directly relevant to the issues in the case. To set this process in motion defendants should file a new petition with the WCJ requesting the SCJ to order the applicant to answer questions on pain of having her application dismissed. Defendants should include in the petition a list of all specific question that they want answered. The defendants should also explain how the questions are directly relevant or would lead to the

discovery of relevant evidence. The WCJ should then order the applicant to answer the relevant questions and issue a notice of intention to dismiss her application if she does not answer the relevant questions. The Panel granted reconsideration and amended the WCJ's findings and order to strike the denial of the order suspending and barring benefits and affirmed the findings and orders as so amended.

Hamilton v. Workers' Compensation Appeals Board, (2011) 76 Cal. Comp. Cases 265 (writ denied) (Compliance with discovery order; admissibility of report of non-examining physician)

Applicant alleged cumulative injury to nineteen body parts or systems from exposure to toxins as a material handler for United Technologies from 1/2002 to 1/2003. The WCJ found applicant did not sustain Psychiatric injury, fibromyalgia, gastrointestinal injury and Multiple Sclerosis on an industrial basis because there was insufficient evidence to support the finding of industrial injury. Applicant filed a petition for reconsideration because defendants failed to provide the applicant with material data safety sheets. She contended that the report of the defense QME should not have been admitted into evidence, that an adverse inference should have been drawn by the WCJ that applicant was exposed to fumes on the job that contributed to her MS based on defendants failure to provide the relevant material data safety sheets, and that the WCJ should have further developed the record.

The WCJ recommend that reconsideration be denied. The defendant had previously been ordered to provide material safety data sheets, and contended that it had complied. Applicant demanded additional material data entry sheets and defendants indicated there were no other material data safety sheets. The WCJ concluded that defendant had complied with the discovery order. The WCJ indicated no physician asked for additional material data entry sheets and the WCJ found all had been provided by defendants. Regarding the admissibility of the defense QME the applicant argued the report of Dr. Markovitz was inadmissible because applicant was never examined by the defense QME. The WCJ stated that there is no authority that the report is inadmissible when the applicant has not been evaluated prior to the preparation of the report. The WCJ indicated the fact the applicant had not been examined goes to the weight not the admissibility of the report. The issue as to the weight would be in the WCJ opinion in connection with the issues when an evaluation would be necessary to the formation of the opinion. The WCJ pointed out in this case the applicant was housebound and not available for medical evaluations and trial. The defendants should have not been prevented from getting a medical examination simply because applicant was unavailable.

The WCJ further pointed out the issue of did the exposure to these chemical cause applicants various medical conditions would not require an examination of the applicant because the AME had access to the applicants deposition transcript, her complete medical file,

and the material data safety sheets. In the opinion of the WCJ the report of the defense QME was substantial evidence without an examination. As the adverse inference the applicant claimed they did not get the sheets for the entire period of exposure, the WCJ concluded that applicant had not demonstrated additional material data safety sheets were necessary and therefore there was no need to draw and adverse inference. The WCJ concluded that, even though an inference could be drawn that applicant was exposed to chemical on the job, as was consistent with the record, no further inference could be drawn regarding causation. The WCJ found no merit in the argument that the WCJ needed to develop the record because the WCJ found the actual evidence of industrial causation was lacking not the medical reports in evidence were lacking. The Workers' Compensation Appeals Board denied reconsideration and the writ was denied.

Green v. HHH, (2011) 39 C.W.C.R. 184 (WCAB Panel) (Discovery of lien claimant's assignment / basis of lien claim.)

The applicant was injured in the course of his work and was hospitalized at St. Francis memorial Hospital. The applicants claim was closed by Findings and Award and the lien was left to be resolved. The hospital transferred the lien to Recovery Resources. CIGA served a *subpoena duces tecum* on Recovery Resources demanding production of contracts, agreements, MOU's, correspondence, e-mails, or documents that evidence the contractual relationship between the hospital and Recovery Resources, limited to medical services, and goods provided for the applicant in this case. Itemization was to include both the procedure settled, where the procedure was for inpatient or outpatient services and the amount of the settlement. Recovery Resources objected and the WCJ quashed the subpoena. The defendants filed a petition for removal.

The WCAB ruled that CIGA was entitled to evidence of the agreements between the hospital and Recovery Resources to determine whether there had been an assignment, explaining that assignment ordinarily refers to transfer of a non-negotiable chose (thing) in action. A thing in action is the right to recover money or other personnel property in a judicial proceeding, and it may be transferred (Civil Code §§953 and 954). Although no particular form is required, there must be a manifestation to another person or owner of the right indicating his intention to transfer, without further action or manifestation of intention, the right to such other person, or to a third person. (*Cockerell v. Title Ins.*, 42 Cal. 2d 284, Civil Code §§1-30). When there is an issue as to whether that has been an assignment, the party claiming the assignment has the burden of proof. (*Wheelon v. Patco*, 258 Cal. 2d 71). CIGA thus had the burden of proof because it contended that the hospitals lien had been transferred to Recovery Resources. The WCAB agreed with the WCJ the subpoena was overbroad and burdensome, but he panel concluded that CIGA was entitled to discover evidence of any contracts between the hospital and Recovery Resources so that it could determine whether there had been a an assignment.

CIGA was not, however entitled to receive privileged information. The WCAB granted removal and set aside the order of the WCJ and remanded the matter back to the WCJ to enable the WCJ with the participation of the parties to develop a discovery plan that will allow CIGA to obtain the documentation it would need in order to sustain its burden of proof as the assignment but does not require the disclosure of privileged material and is not overbroad or unnecessarily burdensome.

MEDICAL LEGAL PROCEDURES:

Messele v. Pitco Foods, Inc., California Insurance Co., (2011) 76 Cal. Comp. Cases 956 (WCAB En Banc) (Length of time before request QME Panel may be made after an offer of AME)

Applicant sustained an admitted injury to her hand and alleges injury to other parts on January 29, 2010. On April 20, 2010, defendant objected to an opinion of the primary treating physician, and advised applicant's counsel of a physician it proposed to serve as an Agreed Medical Examiner. Eleven days later, on May 1, 2011, applicant's counsel submitted a request to the Medical Unit for a QME panel of pain medicine specialists. On May 4, 2011, the fifteenth day after the AME proposal, defendant submitted to the Medical Unit a request for a QME panel in hand surgery. The Medical Unit issued panels in the respective fields in response to each of the requests. Applicant was evaluated by Brendan Morley, M.D., one of the physicians on applicant's panel. The case was heard on the sole issue of which QME panel was proper; defendant contended applicant's panel request was invalid because it had been made before the time for response to the AME offer ran. Applicant's counsel contended ten days had elapsed since the AME offer, and no further time was required by Rule 106 (8 Cal Code of Regs §106.)

The WCJ found that if Code of Civil Procedure §1013(a) applied, it extends the time before which a panel may not be requested by five days, and the first date for a proper request was May 6, 2011 (i.e. both parties requests were invalid). Relying on *Poster v. Southern California Rapid Transit District*, (1990) 52 Cal. 3d 266 (*Poster*), and distinguishing *Camper v. Workers' Comp. Appeals Board*, (1992) 3 Cal. 4th 679; 57 Cal. Comp. Cases 644 (*Camper*) and *Alvarado v. Workers' Comp. Appeals Board*, (2007) 72 Cal. Comp. Cases 1142 (writ den.) (*Alvarado*), the WCJ concluded that Code of Civil Procedure §1013(a) does apply. Defendant's request was received by the Medical Unit on May 10, 2011, and was found to be appropriate. After applicant filed a Petition for Reconsideration, the WCJ recommended that both requests be found to have been premature.

After initially granting reconsideration for study, the Appeals Board concluded that the Finding of Fact was not a final order or determination of substantive rights or liabilities of the

parties, and therefore was not a final order or award. Removal, not reconsideration was the appropriate remedy. The Board granted removal and found that Labor Code §4062.2 is the means by which a medical dispute concerning a represented injured is resolved. Section 4062.2(a) provides in part that “a medical evaluation to determine the disputed medical issue shall be obtained as provided in Section 4062.2, and no other medical evaluation shall be obtained.” Section 4062.2(b) authorizes either party to commence the selection process:

“by making a written request naming at least one proposed physician to be the [Agreed Medical] Evaluator. The parties shall seek agreement with the other party on the physician, who need not be a qualified medical evaluator, to prepare a report resolving the disputed issue.” If no agreement is reached within 10 days of the first written proposal that names a proposed agreed medical evaluator, or any additional time not to exceed 20 days agreed to by the parties, either party may request the assignment of a three-member panel of qualified medical evaluators to conduct a comprehensive medical evaluation. The party submitting the request shall designate the specialty of the medical evaluator, the specialty of the medical evaluator requested by the other party if it has been made known to the party submitting the request, and the specialty of the treating physician....” [Emphasis in Board Decision.]

The Appeals Board then noted that Code of Civil Procedure §1013(a) provides in case of service by mail:

“... any right or duty to do any act or make any response within any period or on a date certain after service of the document, which time period or date is prescribed by statute or rule of court, shall be extended five calendar days, upon service by mail, if the place of address and the place of mailing is within the State of California, 10 calendar days if either the place of mailing or the place of address is outside the State of California but within the United States, and 20 calendar days if either the place of mailing or the place of address is outside the United States.” [Emphasis in Board Decision.]

Where a time limit runs from the date of filing of a document, the extension of time for service by mail does not apply (e.g. time within which to file a Petition for Writ of Review, e.g. in *Camper v. Workers' Comp. Appeals Board*, (1992) 3 Cal. 4th 679; 57 Cal. Comp. Cases 644). However, it does apply to communication of statutory settlement offers. (*Poster v. Southern California Rapid Transit District*, (1990) 52 Cal. 3d 266, at 275.)

The Board noted that Rules of Practice and Procedure §10507, as effective November 17, 2008, provides:

“(a) If a document is served by mail, fax, e-mail, or any method other than personal service, the period of time for exercising or performing any right or duty to act or respond shall be extended by:

“(1) five calendar days from the date of service, if the physical address of the party, lien claimant, attorney, or other agent of record being served is within California;

“(2) ten calendar days from the date of service, if the physical address of the party, lien claimant, attorney, or other agent of record being served is outside of California but within the United States; and

“(3) twenty calendar days from the date of service, if the physical address of the party, lien claimant, attorney, or other agent of record being served is outside the United States.

“(b) For purposes of this section, ‘physical address’ means the street address or Post Office Box of the party, lien claimant, attorney, or other agent of record being served, as reflected in the Official Address Record at the time of service, even if the method of service actually used was fax, e-mail, or other agreed-upon method of service.

“(c) This rule applies whether service is made by the Workers’ Compensation Appeals Board, a party, a lien claimant, or an attorney or other agent of record.”

The Board continued:

“In the present case, defendant mailed its first written AME proposal, so the extensions provided by Rule 10507 and CCP section 1013(a) are the same — five calendar days. The record in EAMS shows that applicant designated U.S. mail as the preferred method of service. (See 8 Cal. Code Regs. § 10218(a).) Defendant’s written AME proposal was sent by mail on April 20, 2010, and applicant responded to it six days later. While there may be other cases where the exact date of service of the first written AME proposal is disputed, there is no doubt or dispute in this case. The WCJ was correct in calculating that May 6, 2010, the 16th day after service of the first written proposal, was the first day on which a valid request for a QME panel could be made. Applicant’s QME panel request shows a “Request date” of May 1, 2010, and defendant’s request shows a “Request date” of May 4, 2010.

“Applicant’s argument that his request was timely is simple. His request was made on the 11th day, and he argued that the five calendar day extension is inapplicable – an argument we reject. Applicant’s request was premature.

“Defendant’s argument that its request was timely is not clearly stated: “[W]hen Defendant made their request for a panel of QMEs waiting the 10 days plus 5 days on May 4, 2010, they waited the proper time as required as it was received by the DWC-Medical Unit on May 10, 2010.” (Defendant’s Answer to Applicant’s Petition for Reconsideration, 3:11-14.) Defendant acknowledges that the five calendar day extension applies, but its conclusion that its request was timely is incorrect. Pursuant to the rule for computing time, which is discussed below and applied in this opinion, defendant’s request — made on the 14th day — was premature as well. Defendant is also incorrect if it argues that the date the DWC Medical Unit received its request is somehow relevant to the request’s timeliness. The action specified in Labor Code section 4062.2(b), which may not occur until after

completion of the required time period for negotiating an AME, is the “request” for a panel QME, not receipt of the request.”

Finally, the Board noted that the method for computation of time runs from the first day after the triggering act, and the count includes the last day, and is the same under Code of Civil Procedure “section 12, Civil Code section 10, ...[or] Government Code section 6800 [which] state the general rule for computation of time, applicable to all statutorily prescribed time periods, regardless of whether they govern the time within which to do something or the time within which a particular action may not be taken.” Here both requests for panels were premature and invalid.

The WCAB will vacate our grant of reconsideration of the WCJ’s non-final decision regarding the properly assigned QME panel. The WCAB deemed applicant’s petition for reconsideration a petition for removal, and they granted removal. As the WCAB Decision After Removal, the WCAB rescinded the WCJ’s finding that Panel No. 1148407 was properly assigned, since defendant’s panel request, like applicant’s, was premature. By counting the days according to the rule articulated in CCP §12, Civil Code §10, and Government Code §6800, and by extending by five calendar days the period for agreeing on an AME, because defendant’s April 20, 2010 written proposal was made by mail, the WCAB determined that the earliest date either party could file a valid QME panel request was May 6, 2010. Therefore, the panels the DWC Medical Unit issued in response to applicant’s May 1, 2010 request and defendant’s May 4, 2010 request were not properly assigned. The WCAB found as follows:

“Neither Panel No. 1148407 nor Panel No. 1148235 was properly assigned, because both panels were requested before expiration of the 10-day period set forth in Labor Code §4062.2(b) for agreement on selection of an AME, plus five calendar days pursuant to WCAB Rule 10507 (Cal. Code Regs., tit. 8, § 10507).”

Messele v. Pitco Foods (II), (2011) 76 Cal. Comp. Cases 1187 (WCAB en banc)
(Prospective application of *Messele*.)

The WCAB granted reconsideration on the Appeals Board own motion under Labor Code §5911 and issued a notice of intention.

On September 26, 2011, the WCAB issued an en banc decision in this case, resolving questions associated with the timeline set forth in Labor Code §4062.2(b) for selecting an agreed medical evaluator (AME) and requesting a panel qualified medical evaluator (QME). They held,

“(1) when the first written AME proposal is ‘made’ by mail or by any method other than personal service, the period for seeking agreement on an AME under Labor Code

§4062.2(b) is extended five calendar days if the physical address of the party being served with the first written proposal is within California; and (2) the time period set forth in Labor Code §4062.2(b) for seeking agreement on an AME starts with the day after the date of the first written proposal and includes the last day.” (*Messele v. Pitco Foods, Inc.*, 76 Cal. Comp. Cases 956, 958 (Appeals Board en banc).) (Footnotes omitted.)

“The intention of the WCAB in issuing the September 26, 2011 decision was to clarify the existing law on issues not previously addressed in a binding Appeals Board decision and to prevent inconsistencies in rulings by WCJs and Appeals Board panels. It was not the intention of the WCAB to throw into uncertainty the validity of QME panels previously obtained in ongoing workers’ compensation proceedings or to allow parties, based on the decision, to challenge the timeliness of a panel request or the validity of panels to which they had not previously objected solely because, after the fact, they were displeased with the make-up of the panel or, worse, because the resulting QME evaluation produced a report unfavorable to their client. It was also not the intention of the WCAB to allow reopening of any orders, decisions, or awards based on our decision. (See Labor Code §§5803, 5804.)

“It came to the attention of the WCAB that the decision of September 26, 2011, while resolving some of the issues relating to the timing of QME panel requests, has created confusion about the status of many ongoing proceedings. The Division of Workers’ Compensation (DWC) has issued DWC Newline No. 46-11 to attempt to manage some of the confusion arising from application of the en banc decision to ongoing cases. In a letter addressed to Chairman Miller from William Herreras of the California Applicants’ Attorneys Association (CAAA) Amicus Curiae Committee, dated October 28, 2011, and served only on Secretary and Deputy Commissioner Dietrich and the President of CAAA, CAAA requested that we modify our decision to make it prospective only.

“In *Farris v. Industrial Wire Products*, (2000) 65 Cal. Comp. Cases 824, 832 (Appeals Board en banc), we stated, “In workers’ compensation cases, it is not uncommon to provide that newly stated judicial rules or newly stated judicial interpretations of statutes shall be applied prospectively only.” (Emphasis added.) To avoid “a landslide of reopening” (*ibid.*; *Atlantic Richfield Co. v. Workers’ Compensation Appeals Board (Arvizu)*, (1982) 31 Cal. 3d 715, 728; [47 Cal. Comp. Cases 500, 509) or other objections to panels, to which the parties had previously acquiesced, and to reports that have already issued and may have formed the basis for settlements, we issue this notice of intention to modify our September 26, 2011 decision to state that it shall apply prospectively, i.e., it shall govern all panel requests made after September 26, 2011.

“Specifically, the WCAB proposed that if, prior to our September 26, 2011 decision, a panel was prematurely but otherwise properly requested and there was no objection on the ground of prematurity, then the resulting panel may not later be challenged on that ground. In other words, if an objection based on prematurity was not made prior to our September 26, 2011 decision, neither party may challenge the request, the ensuing panel, the remaining QME following the striking of names, or the resulting report for prematurity. Of course,

other grounds for challenge may exist and would not be affected by our proposed modification. Moreover, the September 26, 2011 decision would not constitute good cause to reopen any order, decision, or award.

“Pending further action by the Appeals Board, our September 26, 2011 decision remains in full force and effect.

“In addition, we will now correct a clerical error, which appears at page 3, line 17 of our original opinion and in the second sentence of the second paragraph at 76 Cal. Comp. Cases at p. 959. The sentence is corrected to read, ‘He explained in his Opinion on Decision that if CCP §1013(a) applies to extend by five calendar days the 10 days within which to agree on an AME, the first day on which either party could request a panel was May 6, 2010.’ The year was originally indicated incorrectly as ‘2011.’”

The WCAB issued the following orders:

“IT IS ORDERED that reconsideration of the September 26, 2011 Opinion and Decision After Reconsideration, Order Granting Removal, and Decision After Removal (En Banc) is GRANTED ON APPEALS BOARD MOTION.

“IT IS FURTHER ORDERED that the clerical error in the date at page 3, line 17 of our September 26, 2011 Opinion and Decision After Reconsideration, Order Granting Removal, and Decision After Removal (En Banc) be corrected to “May 6, 2010,” and that the parties make the correction by interlineations.

“NOTICE IS HEREBY GIVEN that, absent written comments persuading us to do otherwise, filed and served within ten (10) days of the date of service recited below (plus an additional five (5) days for mailing), the Workers’ Compensation Appeals Board will modify its September 26, 2011 Opinion and Decision After Reconsideration, Order Granting Removal, and Decision After Removal (En Banc) to provide that the principles set forth in the decision shall apply to other cases prospectively from September 26, 2011.”

State Farm Insurance v. Workers’ Compensation Appeals Board (Pearson), (2011) 76 Cal. Comp. Cases 69 (Court of Appeal, partially published) (*Ex parte* communication with “regular physician” prohibited.)

Applicant sustained injuries causing 100% permanent disability and a need for future medical treatment. Applicant’s husband provided her with attendant care and transportation services. The husband filed a lien for these services, claiming 24 hours every day from July 24, 2003 at \$30 per hour for a total of \$1,520,640.00. After initial proceedings regarding the husband’s lien, the WCJ appointed Donna Barras, M.D., as a regular physician under Labor Code 5701 to provide an expert opinion on applicant’s medical and home care needs. Without giving notice to defendant, State Farm, counsel for applicant and her husband contacted Dr.

Barras, scheduled and attended an appointment, and provided her with several medical reports. Dr. Barras reviewed those reports, evaluated applicant, and issued an April 18, 2008 report that, among other things, concluded that the husband was entitled to payment at \$35 per hour, the licensed vocational nursing rate. Defendant later deposed Dr. Barras. Defendant filed a motion to strike Dr. Barras's report, alleging that Applicant's counsel set up the evaluation without notice to it, provided Dr. Barras only with unilaterally selected records, and did not explain to her the nature of the services which the WCJ appointed her to provide. Defendant's motion to strike was placed in issue at a trial on husband's lien. Following trial, the WCJ vacated submission and directed further development of the record. The WCJ agreed that Dr. Barras was not made aware of the purposes for which she was appointed, which included an analysis of whether the husband's services were reasonable and necessary, and found that the husband had unilaterally submitted documents to Dr. Barras for consideration. The WCJ found that these issues did not require Dr. Barras report to be stricken, and instead determined that a supplemental opinion from Dr. Barras could rectify these problems. The WCJ also concluded that Dr. Barras's report required clarification.

After Dr. Barras's May 29, 2009 supplemental report, the matter was re-submitted. The WCJ then issued a decision which accepted Dr. Barras's life care plan for Applicant. Consistent with this life care plan, the WCJ determined that the husband was entitled to be reimbursed for attendant care services for 24 hours per day from July 24, 2003 at \$30 per hour, until implementation of the life care plan by professionals at the employer's expense. On recon, defendant argued that Dr. Barras's reports should have been stricken because the ex parte communication with Applicant and her husband and tainted her reports and that Dr. Barras's reports were not substantial medical evidence because she failed to review complete medical record. Defendant also disputed the husband's caregiver lien. Among other things, State Farm claimed that: (1) he was not entitled to payment for 24 hours per day, seven days per week; and (2) \$30 per hour was excessive because the husband provided only 2.75 hours of medical services each day and the balance of his services involved cooking, cleaning, paying bills, and non-medical errands.

The Appeals Board denied reconsideration. Defendant filed its petition for writ of review.

In the published portion of the decision, the Court of Appeal held that: (1) a regular physician appointed by the WCJ under Labor Code §5701 must be disqualified, and her reports and deposition stricken, because of *ex parte* communications from applicant and her caregiver husband; (2) substantial evidence does not support awarding the caregiver husband at \$30 per hour, seven days a week, 24 hours a day; and (3) some of the caregiver services were not reasonably necessary or did not constitute "medical treatment" that the defendant was required to provide under §4600(a). The Court stated that ex parte communications with respect to the merits with a medical examiner appointed pursuant to Labor Code §5701 are prohibited. All

correspondence concerning the examination and reports of a physician appointed pursuant to Labor Code §5701 shall be made through the Workers' Compensation Appeals Board, and no party, attorney or representative shall communicate with that physician with respect to the merits of the case unless ordered to do so by the Workers' Compensation Appeals Board." (rule10718). The prohibition against ex parte communication attempts to prevent decisions based on information not known to one or both parties. As a general principle, Fundamental fairness in decision making demands both that factual inputs and arguments to the decision maker on law and policy be made openly and be subject to argument by all parties.' " (Department of Alcoholic Beverage Control v. Alcoholic Beverage Control Appeals Board, (2006) 40 Cal. 4th 1, 9.) There are no exceptions for administrative or procedural communications or for other classes of ex parte communication which are not on the merits. (See Alvarez v. Workers' Comp. Appeals Board, (2010) 187 Cal. App. 4th 575, 586-588; 75 Cal. Comp. Cases 817. The prohibition against ex parte communications is a strict rule, and no showing of prejudice is required to invoke the appropriate remedy. The Court annulled the decision of the Appeals Board which had affirmed the decision of the WCJ.

In the unpublished portion of the opinion, the Court of Appeal concluded that defendant did not waive its request to exclude Dr. Barras's report and deposition testimony by failing to object at the time of trial. The Court acknowledged that issues not raised at the trial level cannot be raised for the first time on appellate review. (Griffith v. Workers' Comp. Appeals Board, (1989) 209 Cal. App. 3d 1260, 1265; 54 Cal. Comp. Cases 145.) The Court decided, however, that State Farm did object at the trial level by moving to strike Dr. Barras's report and that it also objected in its petition for reconsideration. The Court further observed that the Appeals Board did not treat the issue as having been waived because it addressed it on the merits.

The Court also decided that husband's caregiver award was unreasonable, not authorized by Labor Code 4600(a), and not supported by substantial evidence. The Court said: A first problem concerns the evidence supporting the finding that the husband monitored and assisted Applicant 24 hours per day, seven days per week. Applicant provided evidence of caregiver services provided by her husband in a list which set forth the daily average times that he provided services. These times do not total 24 hours per day, except for the final item, assist applicant at night, which was listed as 24 hrs. An award of compensation based on the husband's alleged caregiver services 24 hours per day, seven days per week is therefore unreasonable and not substantial evidence did not support the award. A second problem with the evidence of caregiver services allegedly provided is that many of those services do not constitute treatment which the employer is required to provide the injured worker. Care provided by a family member to monitor and manage the industrially injured worker's health care needs may qualify in some cases as medical care under §4600. (Hodgeman v. Workers' Comp. Appeals Board, (2007) 155 Cal. App. 4th 44, 54; 72 Cal. Comp. Cases 1202. A mother

of injured worker, who was also his conservator, could be reimbursed for monitoring and managing her son's health care needs. In *Henson v. Workmen's Comp. Appeals Board*. (1972) 27 Cal. App. 3d 452; 37 Cal. Comp. Cases 564, the worker's treating physician knew that practical nursing services were required and that the worker's wife was providing them. Henson found that the wife could be compensated for those services. In *Smyers v. Workers' Comp. Appeals Board*, (1984) 157 Cal. App. 3d 36; 49 Cal. Comp. Cases 454, held that when a physician recommended or prescribed, for medical reasons, that housekeeping services be performed for the injured worker, those services could be reimbursed under §4600 as medical treatment reasonably required to cure or relieve the effects of the injury. Applicant's list of caregiver services provided by her husband included numerous categories of caregiver services which do not appear to have qualified as medical treatment reasonably required by §4600. The matter must be remanded to the Workers' Compensation Appeals Board to determine which of the caregiver's services that was provided medical treatment pursuant to Labor Code §4600 was. Finally, the Court decided that the caregiver services to be compensated, and the rate of compensation, must be determined. The Court stated that a \$30 hourly payment for services which are not included under §4600, subdivision (a) is unreasonable and is an act in excess of the powers of the appeals board and the hourly rate of compensation was excessive for categories of services provided which were not LVN services. Other services provided by husband did not appear to have been medically necessary, and were not services that §4600, subdivision (a) required the employer to provide or for whose expense the employer was liable. The decision of the Workers' Compensation Appeals Board was reversed and the matter remanded.

Koeing v. AT&T Mobility, (2011) (39 C.W.C.R. 37 (WCAB Panel) (Exception to *ex parte* communication requiring disqualification)

Applicant went to a panel QME in Psychology. After a reevaluation on August 28, 2009 the QME wrote report dated October 26, 2009. In the second week of October the applicant called the QME and told her she was having obsessive thoughts about hitting her step father with a rubber baseball bat. The applicant stated during the call she was felling anxious and pressured. The applicant was felling fear and concern over these thoughts. Defendant filed a motion to strike the QME report for *ex parte* communication pursuant to Labor Code §4062.3(f). The WCJ denied the motion and the defendants filed a petition for removal.

The Workers' Compensation Appeals Board majority ruled that the communication was made in the course of the examination and not precluded by the prohibition of Labor Code §4062(3) even though the communication was made by phone after the reexamination was completed. The dissent felt the communication was not part of the examination and was *ex parte* as it occurred six weeks after the reexamination.

EARNINGS / COMPENSATION RATES, 4658(d), COLA and SAWW:

Baker v. Workers' Compensation Appeals Board, (2011) 52 Cal. 4th 434; 76 Cal. Comp. Cases 701 and 714; noted 39 C.W.C.R. 169 (Date from which COLA is applied to total Permanent Disability and life pension cases.) (KAHN)

The Supreme Court construed Labor Code §4659, subdivision (c) to require the annual COLA's for total permanent disability and life pension payments, that the Legislature intended that COLA's be calculated and applied prospectively commencing on the January 1 following the date on which the injured worker first becomes entitled to receive, and actually begins receiving, such benefit payments, i.e., the permanent and stationary date in the case of total permanent disability benefits, and the date for commencement of application of COLA on life pension is the first of the year following that on which partial permanent disability benefits become exhausted.

The Supreme Court construed Labor Code §4659, subdivision (c) to require the annual COLA's for total permanent disability and life pension payments, that the Legislature intended that COLA's be calculated and applied prospectively commencing on the January 1 following the date on which the injured worker first becomes entitled to receive, and actually begins receiving, such benefit payments, i.e., the permanent and stationary date in the case of total permanent disability benefits, and the date on which partial permanent disability benefits become exhausted in the case of life pension payments.

The opinion in above matter filed on August 11, 2011, was modified as follows: ++++
The modification does not affect the judgment.

County of Fresno v. WCAB (O'Brien), (2011) 39 C.W.C.R. 202 (Unpublished)
(Application of *Baker*.)

In an unpublished memorandum the Court of Appeal noted the method of calculating COLA payment set forth by the Court in *Duncan* was overruled by the Supreme Court in *Baker* the same case under a new name. The Supreme Court acknowledged three methods of assessing the COLA: (1) prospectively from January 1 following the year in which the worker first becomes entitled to PD or life pension benefits,(2) retroactively to January 1, 2004 following the year in which the injury occurred, (3) retroactively to January 1, 2004 in very case regardless of the date of injury. The Supreme Court rejected both retroactive theories and held the prospective method was correct. The court noted that in this case that substantial evidence supported the finding of 100% disability in 2003. That would give a basis to start the COAL in 2004. The parties however stipulated to 2008 and the P and S date when PD payments actually began. Based on the stipulation the COLA would have begun January 1, 2009. The WCAB did not apply the Baker holding on the COLA. The Court granted the writ and remanded the

case to reconsider its decision in light of Baker, including making a determination whether the stipulation on a P and S date was made was insufficient or whether some other date, even as early as 2003, should be used based on the medical evidence.

Crews v. Methodist Hospital, (2011) 39 C.W.C.R. 13 (WCAB Panel) (Earnings capacity of student engaged in part time employment.)

At the time of the injury applicant was working part time as a therapy aide approximately 25 hours each week. H earned \$9.81 per hour and he was attending school full time. At the hearing the parties stipulated to PD and among the issues to be submitted were earnings, compensation rates, and the EDD lien. Offered into evidence at the hearing was a wage statement calculating applicants average weekly earnings by dividing her yearly salary of \$10,739.94 by 50 weeks. The applicant testified she that after completing two years of junior college she entered California State University at Los Angeles with the goal of obtaining a B.S. degree in Kinesiology. If she had not been going to school she would have been working full time. It was her understanding that occupational therapists earn \$25 an hour.

The WCJ found that applicant earnings were \$245.25 (\$9.81 times 25 hours) and EDD was entitled to allowance of it lien. Both parties petitioned for reconsideration. The Workers' Compensation Appeals Board granted reconsideration.

The Workers' Compensation Appeals Board stated that TD is intended as wage replacement during the time the employee is unable to work and PD is intended to reimburse the injured worker for impairment of future earning capacity. (*Ritchie* 59 Cal. Comp. Cases 243). Labor Code §4453 (c) sets forth the 5 methods for calculating compensation rate. §4453 (C) (4) provides for employees working less than 30 hours a week, or if for any reason the other sections for calculating earnings cannot be fairly or reasonably applied average weekly earnings shall be take at 100% of the sum which reasonably represents the average weekly earnings at the time of the injury. Thus the Workers' Compensation Appeals Board concluded that when actual earnings are not indicative of the employees real wage loss, lost earning may be calculated by a better measure. In determining lost earning capacity consideration must be given to the worker's ability, willingness, and opportunity to work. (*Argonaut Ins. Co. v. Industrial Accident Commission (Montana)*, (1962) 57 Ccal. 2d 589; 27 Cal. Comp. Cases 130) Calculating the average weekly earnings by multiplying the hourly rate by the number of hours worked each week may not be enough.

In the present case the Workers' Compensation Appeals Board concluded that the record was not adequate to determine applicant's opportunities for full time work and what her earnings would have been if she worked full time, the record needed further development. The intent of a student to work full time in the future is relevant in determining earning

capacity; the effect of the studies had to be taken into account. The intent of the student to work full time in the future is relevant in determining earning capacity, and career plans are evidence that a student intends to do so. More evidence was needed on how long the applicant was likely to remain in school and on the actual earnings of occupations therapists in the area. In response to the defendants Petition the Workers' Compensation Appeals Board stated that pursuant to Labor Code 4903 and 4904, EDD is allowed a lien for benefits that it pays for a period that an injured worker is entitled to TD or PD. EDD's lien was against applicant's compensation and was not defendant's direct liability. To the extent that that defendant reimbursed EDD for its payment, defendant was entitled to credit, and the WCJ need to so find. Reconsideration was granted and the matter was remanded for further proceedings.

Allied Waste Industries, Inc. et al. v. Workers' Compensation Appeals Board (Rojas), (2010) 75 Cal. Comp. Cases 1315 (Unpublished) (Permanent disability – COLA adjustments to life pension rate begin the January 1st after date of injury. NOW OVERRULED.)

Applicant sustained an injury in February 2005. The WCJ found that applicant was entitled to a COLA as of 1/1/04, the date specified in §4659(c) as the start date for the adjustment. Defendant sought reconsideration.

The Workers' Compensation Appeals Board affirmed the determination that applicant was entitled to a COLA as of 1/1/04. Both the WCJ and the WCAB felt constrained by the appellate decision in *Duncan*, which had determined 1/1/04 to be the COLA's effective date in all cases. Defendant filed a Petition for Writ of Review. Two days after the Workers' Compensation Appeals Board's decision, on the Supreme Court granted review in *Duncan*.

The Court granted the writ. It noted that Labor Code §4659(c) offers three possible start dates for this COLA: (1) January 1, 2004; (2) the January 1st following a rating of permanent total disability; or (3) the January 1st following the date of injury. It rejected defendant's contention that the adjustments should commence the year after applicant is found to be permanent and stationary.

The Court concluded that "under the plain language" of §4659(c), the COLA takes effect on the January 1st following the date of injury. Before being reversed by the 6th Appellate District, this is what the WCAB had held in *Duncan*. Thus, in this case, the COLA should be calculated as of January 1, 2006. C.f. *Baker*.)

Motheral v. Workers' Compensation Appeals Board, Golden Empire Council, BSA, (2011) 199 Cal. App. 4th 148; 76 Cal. Comp. Cases 720, (Lodging, meals, and transportation allowance to be included with wages in determining earnings.)

Motheral was injured at work in August 2007 and was paid temporary total disability benefits from the date of his injury. The parties disputed whether Labor Code §4454 required that the market value of Motheral's living quarters, utilities, and car allowance should be included in computing his average weekly earnings and his resulting disability payment. §4453 provides in pertinent part:

“In determining average weekly earnings . . . , there shall be included . . . the market value of board, lodging, fuel, and other advantages received by the injured employee as part of his remuneration, which can be estimated in money”

Bill Motheral worked as a camp ranger for Golden Empire Council, Boy Scouts of America (the Council). He was paid an annual salary equal to 40 hours per week at the minimum wage. His employment contract specified that his salary “include[d] \$5,055 per year for [his] living quarters and utilities (gas, electricity and telephone) at the ranger's residence” It also provided that he would receive \$187.50 a month “for use of [his] vehicle for business” This appeal concerns the calculation of an injured employee's “average weekly earnings” for purposes of determining his temporary disability benefits. (Labor Code, §4653.)

The WCJ calculated Motheral's average weekly earnings based solely on his full-time employment (40 hours per week) at the minimum wage, finding it was unnecessary to determine the value of the living quarters and utilities “because it was the parties' intent to pay the applicant at the minimum wage.” The Workers' Compensation Appeals Board (Board) denied Motheral's petition for reconsideration. Applicant filed a Petition for Writ of Review.

A writ of review was granted. Calculation of average weekly earnings for purposes of determining temporary total disability rate is calculated as “two-thirds of the average weekly earnings during the period of such disability” (§4653, italics added.) Pursuant to §4454, “the market value of board, lodging, fuel, and other advantages received by the injured employee as part of his remuneration, which can be estimated in money,” shall be included in determining average weekly earnings. Such average weekly earnings, however, “shall not include any sum which the employer pays to or for the injured employee to cover any special expenses entailed on the employee by the nature of his employment” (Ibid.) “Determining whether fuel, lodging, and meals are ‘remuneration’ or ‘special expenses’ requires an analysis of several factors including whether they were provided in exchange for services, whether they are an advantage to the applicant, and whether they are provided to the applicant only while the applicant is performing employment duties.” (*Burke v. Workers' Compensation Appeals Board*, (2009) 74 Cal. Comp. Cases 359, 363 (writ den.)) “Lodging is

remuneration if an employee is provided with lodging in exchange for services and that lodging is an economic advantage to the applicant.” (Ibid.) “[F]uel is remuneration if the employee is provided with fuel in exchange for services. Fuel and other travelling expenses have been found to be remuneration where the employer doesn’t reimburse the employee for travelling expenses, but rather pays the employee a fixed amount, whether or not the employee actually travels.” (Id. at p. 364.) Applying those standards here, there is no question that the lodging, utilities, and car allowance Motheral received were remuneration, and therefore, should have been considered in calculating his average weekly earnings and resulting temporary disability payment. The car allowance was to be paid regardless of how much or even whether Motheral drove, and therefore, constituted remuneration. (*Burke*, supra, 74 Cal. Comp. Cases at p. 364.) Accordingly, it, too, should have been included in the calculation of Motheral’s average weekly earnings. On remand, the Board is directed to recalculate Motheral’s average weekly earnings using his minimum wage salary, less the applicable lodging credit, plus the market value of his living quarters, utilities (gas, electric, and local telephone service), and one quarter of his monthly car allowance. The Board’s order denying Motheral’s petition for reconsideration is annulled. The matter is remanded for further proceedings consistent with the views expressed herein. Motheral shall recover his costs on appeal. (Cal. Rules of Court, rule 8.493(a)(1)(A).)

TEMPORARY DISABILITY:

L. A. County Fire Dept. v. Workers’ Compensation Appeals Board (Beck, Leland), (2011) 76 Cal. Comp. Cases 45 (Writ denied) (No limit on commencement or duration of Temporary Total Disability for an injury occurring between 1979 and 4/18/2004 where there is original jurisdiction.)

Applicant sustained cumulative injury AOE-COE through 6/29/2002. He was paid TTD for three broken periods through 1/23/2003. He sought further TTD for six weeks following hip replacement surgery. Defendant disputed liability contending applicant became P&S 7/28/2004, and this TD period commenced more than five years after the date of injury. The WCJ awarded the temporary disability commencing in 2009. Defendant sought reconsideration.

The Workers’ Compensation Appeals Board held that pursuant to Labor Code §4656, there is no time limit on TD payments were the injury occurred on or after January 1, 1979 and before April 19, 2004. The Workers’ Compensation Appeals Board has jurisdiction to award TD for a period that commences more than five years after the date of injury if the issue of applicant’s entitlement to TTD remains pending and unresolved more than five years after the date of injury. (*Central Wholesale*, 73 Cal. Comp. Cases 255, W/D and *Denny’s*, 71 Cal. Comp. Cases 831, W/D) Where there is no prior award or decision, the Workers’

Compensation Appeals Board has jurisdiction to award TD for a period commencing more than five years from the date of injury, when jurisdiction had continued over the issue of TD benefits. (*Unigard Insurance*, 59 Cal. Comp. Cases 966, W/D) Thus the Workers' Compensation Appeals Board is not required to make an initial determination on TD within five years of the date of injury.

The holding in the case of *Nickelsburg*, (56 Cal. Comp. Cases 476), is not controlling because the court in *Nickelsburg* held the Workers' Compensation Appeals Board has no jurisdiction to award **additional** TD beyond five years from the date of injury where the injured employee claim for benefits **had been the subject of a final award** unless the Workers' Compensation Appeals Board has jurisdiction to amend the original award pursuant to Labor Code §§ 5803, 5804, and 5410. In this case because there had been no final adjudication of the case and the injury occurred between January 1, 1979 and April 19, 2004 the Workers' Compensation Appeals Board had original jurisdiction, hence jurisdiction to award TD over five years from the date of injury. The Writ was denied.

Cubedo v. Leemar Enterprises, Inc., (ADJ7014822), 2011 Cal. Wrk. Comp. P.D. LEXIS 356 (Temporary partial disability indemnity for illegal alien.)

Applicant who suffered an admitted industrial spine injury on 6/24/2009 while employed by Defendant as a cashier. Applicant was authorized to return to limited duty, and defendant contended that it had work available within the limitations, but that applicant was precluded from undertaking it due to his immigration status. Here the employer would offer an employee modified work prior to the employee's permanent and stationary status but cannot because the injured worker is an illegal worker and to do so would subject its officers to civil penalties, criminal fines and possible imprisonment. Here, the WCJ awarded temporary total disability benefits because of the applicant's loss of all income during the period.

Defendant sought reconsideration challenging the temporary disability award. Defendant alleged that Applicant was medically eligible to work in a modified capacity during the period for which she was awarded temporary total disability benefits, but could not accept modified work solely because of her undocumented work status. California Labor Code Section 1171.5 indicates that all protections, rights and remedies are available to all individuals regardless of their immigration status. In *Del Taco v. Workers' Comp. Appeals Board* (2000) 79 Cal.App.4th 1437; 65 Cal. Comp. Cases 342, the California Court of Appeals held that though the immigration status of an injured worker is not relevant to the issue of temporary disability, the injured worker was not entitled to vocational rehabilitation benefits where the employee is not able to return to work solely because of his immigration status.

Defendant contended, in relevant portion, that by awarding temporary total disability benefits to Applicant, an illegal resident, the WCJ violated the Equal Protection Clause of the 14th Amendment to the United States Constitution.

The WCAB granted reconsideration and rescinded the WCJ's decision, holding that the WCJ's award of temporary total disability indemnity was not supported by substantial evidence and was inconsistent with the holding in *Del Taco v. Workers' Comp. Appeals Board* (2000) 79 Cal. App. 4th 1437, 65 Cal. Comp. Cases 342. In *Del Taco v. Workers' Comp. Appeals Board* (2000) 79 Cal. App. 4th 1437; 65 Cal. Comp. Cases 342, the Appeals Court held that, although an injured worker's immigration status is not relevant to the issue of entitlement to temporary disability, the injured worker is not entitled to vocational rehabilitation benefits where the employee is unable to return to work solely because of immigration status.

According to the WCAB, the evidence, including reports of Applicant's treating physicians and the panel QME, established that Applicant suffered temporary disability following her industrial injury, but was only partially disabled and was able to work in a modified job for some periods of her temporary disability. Testimony offered at trial by both Applicant and two defense witnesses indicated that Applicant was offered modified work and worked in a modified position, but ultimately stopped working due to her undocumented work status. Applicant also testified that she stopped working for Defendant in July 2009 due to her industrial injury.

In its Decision After Reconsideration, the WCAB explained that, in 2002, the California Legislature declared that the immigration status of a person employed in California is irrelevant when it comes to extending "all protections, rights and remedies available under state law." The only exception to this protection limits the imposition of the remedy of reinstatement to employment if reinstatement would be prohibited under federal law. The WCAB also noted as follows:

In addressing the issue of entitlement to temporary disability, the *Del Taco* Court stated that:

"Worker's immigration status does not affect his entitlement to temporary disability payments. As indicated, the workers' compensation statutes apply to 'every person in the service of an employer ... whether lawfully or unlawfully employed, and includes: [] (a) Aliens and minors.' (§ 3351.) A citizen or legal resident alien would be entitled to disability benefits if he or she had been injured while working for Del Taco under comparable facts. Here, worker is unable to work as a result of the work related injury and is entitled to disability benefits wherever he is residing, legally or illegally." (*Del Taco, supra*, 65 Cal. Comp. Cases 342, at p.345.)

"Nevertheless, with regard to the issue of entitlement to vocational rehabilitation services, the Court found that, where it is an injured worker's immigration status that precludes him or her from returning to work, the injured worker is not entitled to vocational

rehabilitation services as awarding such benefits would deprive the employer from equal protection under the 14th Amendment to the United States Constitution.” (*Del Taco, supra*, 65 Cal. Comp. Cases 342, at p.345.)

Here, applicant’s treating physician found her to be temporarily totally disabled from at least March 29, 2010 to April 26, 2010 and from May 3, 2010 to June 1, 2010. The WCAB determined that during these periods and any other periods during which Applicant was temporarily **totally** disabled based on substantial evidence, applicant was entitled to temporary disability benefits pursuant to the holding in *Del Taco*. However, the WCAB found that if defendant made a legitimate offer of modified work that applicant could not accept solely because of her residency status, defendant was not alternatively liable for temporary total disability benefits..

Because there was conflicting testimony regarding whether and for what periods Applicant worked in a modified capacity, and there were no wage records in evidence, the WCAB concluded that the record was not sufficiently developed to determine the issue of Applicant’s entitlement to temporary disability for the entire period from June 24, 2009 to the present, as awarded by the WCJ. Accordingly, the WCAB remanded the matter to the trial level for further proceedings to develop the record on these issues.

Popovich v. Workers Compensation Appeals Board, (2011) 199 Cal. App. 4th 148; 76 Cal. Comp. Cases 1050 (Court of Appeal, Third Appellate District) (Temporary disability, right to reopen in insidious disease claims)

Petitioner Jayna Popovich sustained a cumulative injury to her liver, diagnosed in 1999 as Hepatitis C, arising from her employment as a correctional officer with respondent Department of Corrections and Rehabilitation. In August 2000, she filed an application for adjudication of claim with the Board and, on September 5, 2002, the parties entered into a stipulation that petitioner had not yet suffered either temporary or permanent disability as a result of the injury. The stipulation further stated: “Parties stipulate that Hepatitis C is an insidious disease process that extends the jurisdiction of the [Board] beyond the statutory 5 years. This finding is based upon the report of the AME, Ira Fishman M.D. dated 2/22/02 and 1/25/02.” The Board entered an award in accordance with the stipulation. The stipulation cited *General Foundry*.

In *General Foundry Service v. Workers’ Compensation Appeals Board*, (1986) 42 Cal. 3d 331 (*General Foundry*), the California Supreme Court held the limitation period for reopening does not apply to an award of permanent disability benefits in cases of insidious, progressive diseases, which have long latency periods.

On July 3, 2009, petitioner filed a petition to reopen for new and further disability, seeking an award of temporary total disability. The parties submitted the matter to the Board on the

issue of whether the 2002 reservation of jurisdiction “allowed for an award of temporary disability more than 5 years after the date of injury.”

The WCJ denied the petition, concluding he had no jurisdiction to award temporary disability benefits more than five years after the injury, because the reservation of jurisdiction applied only to permanent disability benefits.

Labor Code §5410 reads: “Nothing in this chapter shall bar the right of any injured worker to institute proceedings for the collection of compensation . . . within five years after the date of the injury upon the ground that the original injury has caused new and further disability The jurisdiction of the appeals board in these cases shall be a continuing jurisdiction within this period. . . .” (Italics added.) Section 5804 states: “No award of compensation shall be rescinded, altered, or amended after five years from the date of the injury except upon a petition by a party in interest filed within such five years” (Italics added.)

In *General Foundry*, the California Supreme Court carved out an exception to the foregoing five-year limitations for “insidious, progressive diseases.” (*General Foundry*, supra, 42 Cal.3d at p. 338.) For such diseases, which have long latency periods and may not become permanent and stationary within five years, the Board “may reserve jurisdiction on the question of permanent disability and continue its jurisdiction beyond the five-year period.” (*Barnes v. Workers’ Compensation Appeals Board*, (2000) 23 Cal.4th 679, 687; *General Foundry*, supra, 42 Cal.3d at p. 338.)

Petitioner filed a petition for reconsideration, which the Board denied. The Board concluded *General Foundry* does not apply to awards of temporary disability benefits and denied relief. Applicant sought review.

The Court of Appeal granted review and concluded that *General Foundry* is inapplicable to the present matter, because the five-year limitation period did not begin to run until petitioner suffered disability, which did not occur until 2009. Therefore, the Petition to Reopen was timely. The Court held:

“The [Board] is vested with the authority and jurisdiction to conduct proceedings for the recovery of compensation. (Labor Code §5300 et seq.) Concomitantly, it is empowered with continuing jurisdictional authority over all of its orders, decisions and awards. (Labor Code §5803.) However, this power is not unlimited.” (*Nickelsberg v. Workers’ Compensation Appeals Board*, (1991) 54 Cal.3d 288, 297.) The power to alter a prior award is subject to Labor Code §§5410 and 5804. (Ibid.)”

In the present matter, the Board concluded *General Foundry* does not apply to temporary disability benefits. In *Hartsuiker v. Workers’ Compensation Appeals Board*, (1993) 12

Cal.App.4th 209 (*Hartsuiker*), the Court of Appeal concluded the Board has no authority to reserve jurisdiction for the purpose of awarding temporary total disability benefits more than five years after the date of injury. (Id. at p. 211.) While recognizing the public policy that “workers should be compensated when they are required to forego work in order to obtain necessary treatment for their industrial injuries[,]” the court explained the present statutory scheme simply does not allow for it. (Id. at p. 219.)

Hartsuiker is inapposite, because it did not involve an insidious, progressive disease, as in this case or in *General Foundry*. Thus, the question remains whether the exception carved out in *General Foundry* should be extended to temporary disability benefits.

In *MacDonald v. Western Asbestos Company*, (1982) 47 Cal. Comp. Cases 365 (*MacDonald*), the applicant worked as an asbestos installer until his retirement in 1972 and did not develop lung symptoms until seven years later. The WCJ found temporary total disability beginning July 1, 1980. However, because the applicant had already withdrawn from the labor market, he was found not to be entitled to temporary disability benefits. (Id. at pp. 365-366.) The Board disagreed and awarded benefits at the minimum rate. According to the Board, if it were to conclude otherwise, “the delay in the onset of disability, due to the insidious nature of the industrial disease, would produce a windfall to the employer by relieving it of the payment of disability benefits which arise because of injuries occurred [sic] in the course of or arising out of employment.” (Id. at p. 368.)

In their 2002 stipulation, the parties cited both *General Foundry* and *MacDonald*. Petitioner contends it may be inferred from this that the parties intended the reservation of jurisdiction to apply both to permanent and to temporary disability benefits.

Of course, the fact the parties may have intended that Board jurisdiction extend beyond the five-year limitation period does not make it so. The question remains whether the Board had the legal authority to reserve jurisdiction to award temporary disability benefits beyond the limitations period.

But the court stated that they need not decide that issue. In their stipulation, the parties also cited *Chavira v. Workers’ Compensation Appeals Board*, (1991) 235 Cal. App. 3d 463 (*Chavira*). In *Chavira*, the Court of Appeal undertook an extensive discussion of when a worker with an insidious, progressive disease sustains an injury for purposes of filing a workers’ compensation claim. Section 5412 states: “The date of injury in cases of occupational diseases or cumulative injuries is that date upon which the employee first suffered disability therefrom and either knew, or in the exercise of reasonable diligence should have known, that such disability was caused by his present or prior employment.” An application for benefits must be filed within one year of the date of injury. (Labor Code §5405.) The court

indicated disability for purposes of Labor Code §5412 means either temporary disability, i.e., loss of earnings, or permanent disability, i.e., loss of earning capacity with or without an actual loss of earnings. (*Chavira*, at pp. 473-474.)

In their 2002 stipulation, the parties indicated petitioner had not yet suffered any temporary or permanent disability. The court therefore requested supplemental briefing on two issues: (1) whether petitioner suffered a disability in 2002 for purposes of determining the date of injury, and (2) if not, when the five-year limitation period began to run. Both parties responded, agreeing that petitioner did not suffer a disability until 2010 and the limitation period did not begin to run until then.

In light of the parties' responses and the record before us, the court concluded that the Board erred in concluding the petition to reopen for an award of temporary disability was untimely. The decision of the Board must therefore be vacated and the petition to reopen must be considered on the merits.

The order of the Board on reconsideration was annulled and the matter remanded for further proceedings consistent with the views expressed in this opinion. Petitioner was awarded costs incurred in the appeal.

Connecticut Indemnity Insurance Co., v. Workers' Compensation Appeals Board (Barnett) 76 Cal Comp Cases 1204 (Writ denied) On timely petition to reopen, there is jurisdiction to award temporary disability for a period beginning within five years of date of injury.

Applicant sustained injury to his knees and hops on May 28, 2002. He underwent a total right knee replacement surgery, and became permanent and stationary on September 30, 2003 in the treating physician's opinion or February 12, 2004 in the AME's opinion. The case was closed by Stipulations with Request for Award and award finding 27% permanent disability, on February 5, 2005. On May 2, 2007, applicant filed a Petition to Reopen. Applicant ad been reported to have worsening knee problems since April 2007, and on January 21, 2008, applicant had a total knee replacement surgery. The AME reported that applicant had been temporarily totally disabled from April 25, 2006 to and including February 4, 2009. After hearing the WCJ found that applicant was entitled to temporary disability indemnity for the period April 25, 2006 to and including February 4, 2009, and 70% permanent partial disability. Defendant sought reconsideration contending that applicant suffered no wage loss during the ttd period, that the ttd period was beyond the five year limitation, and that no substantial evidence supported the award. The WCJ noted the AME's opinion as substantial evidence, noted that there had been a timely Petition to reopen, and that the period of temporary disability awarded commenced within five years of the date of injury.

The Appeals Board denied reconsideration, and defendant's petition for writ of review was denied.

PERMANENT DISABILITY

Ogilvie v. Workers' Compensation Appeals Board, (2011) 197 Cal. App. 4th 1262; 76 Cal. Comp. Cases 624; 39 C.W.C.R. 169 (First Appellate District). (Means to rebut the 2005 PDRS.)

The court stated that the issue was what showing is required by an employee who contests a scheduled rating on the basis that the employee's diminished future earning capacity is different than the earning capacity used to arrive at the scheduled rating? The Court concluded that the DFEC component of a scheduled PD rating is rebuttable. The Court then identified three rebuttal methods: (1) showing a factual error either in the DFEC adjustment factor or in its application in the rating formula; (2) demonstrating through a *LeBoeuf*-type approach that the injured employee is not amenable to vocational rehabilitation (VR) and, therefore, the employee's diminished future earning capacity is greater than that reflected in the employee's scheduled rating; or (3) demonstrating that the amalgamation of data used to arrive at the DFEC adjustment factor does not capture the severity or all of the medical complications of the employee's injury. The Court concluded that the Workers' Compensation Appeals Board acted in excess of its authority when it devised the rebuttal approach of its en banc decisions in *Ogilvie I* and *Ogilvie II*. Accordingly, the Court annulled those decisions and remanded for further proceedings consistent with its opinion. The Court's concluded that there is no meaningful difference between diminished future earning capacity of current Labor Code 4660(a) and the diminished ability to compete in an open labor market of former Labor Code 4660(a). The Court then stated that the specification in §4660, subdivision (b)(2), that an employee's diminished future earning capacity shall be a numeric formula based on empirical data and findings as developed by the RAND Institute provides no alternative means to take into account the diminished earning capacity of an employee. While the rating schedule is to be prima facie evidence, there is no indication some other measure may be substituted for the earning capacity component. The DFEC adjustment factor must be initially applied. The ambiguity lies in determining just how an employee's overall rating and its component parts may be rebutted while remaining loyal to the Legislature's design to provide a system that is objective and uniform in application. Looking back at over 41 years of case law interpreting §4660, there appear to be at least two rebuttal methods that are unchanged by passage of Senate Bill No. 899. First of all, the cases have always recognized the schedule to be rebutted when a party can show a factual error in the application of a formula or the preparation of the schedule. A challenge to an employee's presumptive disability rating thus appears to remain permissible on the basis that the schedule, or one of its component factors, was incorrectly

calculated or applied. An interpretation that the diminished earning capacity adjustment factor must be applied as formulated by the administrative director in all cases irrespective of its accuracy would have required the court to read into §4660 a conclusive presumption. Such a restrictive interpretation of §4660 would be inconsistent with the Legislature's clear expression that the rating schedule is rebuttable. The Court next focused on a *LeBoeuf*-type rebuttal. Another way the cases have long recognized that a scheduled rating has been effectively rebutted is when the injury to the employee impairs his or her rehabilitation, and for that reason, the employee's diminished future earning capacity is greater than reflected in the employee's scheduled rating. This is the rule expressed in *LeBoeuf v. Workers' Comp. Appeals Bd.* (1983) 34 Cal.3d 234; 48 Cal. Comp. Cases 587. In *LeBoeuf*, an injured worker sought to demonstrate that, due to the residual effects of his work-related injuries, he could not be retrained for suitable meaningful employment. The Supreme Court concluded that it was error to preclude such a showing, and held that the fact that an injured employee is precluded from the option of receiving rehabilitation benefits should also be taken into account in the assessment of an injured employee's permanent disability rating. The court went on while some suggest that under *LeBoeuf* a disability award may be affected when an employee is not amenable to vocational rehabilitation for any reason, the most widely accepted view of its holding, and that which appears to be most frequently applied by the re, is to limit its application to cases where the employee's diminished future earnings are directly attributable to the employee's work related injury, and not due to nonindustrial factors such as general economic conditions, illiteracy, proficiency to speak English, or an employee's lack of education. Accordingly, an employee effectively rebuts the scheduled rating when the employee will have a greater loss of future earnings than reflected in a rating because, due to the industrial injury, the employee is not amenable to rehabilitation. The Court then discussed a third rebuttal method. The court stated the briefs and arguments of the parties and amici also point out a third basis for rebuttal of a scheduled rating that is consistent with the statutory scheme. In certain rare cases, it appears the amalgamation of data used to arrive at a DFEC adjustment may not capture the severity or all of the medical complications of an employee's work-related injury. After all, the adjustment is a calculation based upon a summary of data that projects earning losses based upon wage information obtained from EDD for a finite period and comparing the earnings losses of certain disabled workers to the actual earnings of a control group of uninjured workers. A scheduled rating may be rebutted when a claimant can demonstrate that the nature or severity of the claimant's injury is not captured within the sampling of disabled workers that was used to compute the adjustment factor. For example, a claimant who sustains a compensable foot fracture with complications resulting from nerve damage may have greater permanent effects of the injury and thereby disprove the scheduled rating if the sampling used to arrive at the rating did not include any workers with similar complications. In such cases, the scheduled rating should be recalculated taking into account the extent to which the claimant's disability has been aggravated by complications not considered within the sampling used to compute the adjustment factor. In this way, the

employee's permanent disability rating gives consideration to an employee's diminished earning capacity that remains based upon a numeric formula based upon empirical data and findings prepared by the RAND Institute. The court finally stated that they would leave it to the Workers' Compensation Appeals Board in the first instance to prescribe the exact method for such a recalculation that factors the employee's anticipated diminished earning capacity into the data used by the RAND Institute.

The Court then stated that although Senate Bill No. 899 enacted extensive changes to California's workers' compensation system, the rebuttable presumption in §4660 was unaltered. The result the court reached in this case furthered the Legislature's objectives by ensuring that an injured worker may dispute his or her scheduled rating on the grounds that it does not accurately reflect that worker's true diminished earning capacity due to an industrial injury. The court concluded that an employee may challenge the presumptive scheduled percentage of permanent disability by showing a factual error in the calculation of a factor in the rating formula or application of the formula, the omission of medical complications aggravating the employee's disability in preparation of the rating schedule, or by demonstrating that due to industrial injury the employee is not amenable to rehabilitation and therefore has suffered a greater loss of future earning capacity than reflected in the scheduled rating. The application of the rating schedule is not rebutted by evidence that an employee's loss of future earnings is greater than the earning capacity adjustment that would apply to his or her scheduled rating due to nonindustrial factors. Rather, to rebut the application of the rating schedule on the basis that the scheduled earning capacity adjustment is incorrect, the employee must demonstrate an error in the earning capacity formula, the data or the result derived from the data in formulating the earning capacity adjustment. Alternatively, an employee may rebut a scheduled rating by showing that the rating was incorrectly applied or the disability reflected in the rating schedule is inadequate in light of the effect of the employee's industrial injury. Nothing in Senate Bill No. 899 authorizes or compels the calculation of an alternative diminished earning capacity adjustment factor as the Workers' Compensation Appeals Board devised in order to resolve Ogilvie's claim. The means an employee may use to challenge a scheduled rating due to diminished earning capacity are described in the reported cases that predate Senate Bill No. 899. Here, vocational experts determined that Ogilvie's anticipated loss of future earnings will be greater than reflected in a permanent disability award based on the rating schedule. Because we cannot determine on this record the degree to which the experts may have taken impermissible factors into account in reaching their conclusions, the court remanded for further proceedings.

Paine v. City of Sebastopol, (2011) 39 C.W.C.R. 16 (WCAB Panel) (Labor Code §4658(d) adjustment.)

The parties stipulated Injury, PD, Period of TD, defendants received the final report of the PTP on November 2008, offer of regular work in December 2008, Receipt of a panel QME report March 9, 2009, two lump sum payments of PD in March and April 2009, all payments made at the 15% reduced rate. The WCJ ruled the defendant was not entitled to the 15% reduction pursuant to Labor Code §4658(d)(3)(a) because all PD payments were due and payable before the permanent and stationary date. Defendants filed a petition for Reconsideration.

The Workers' Compensation Appeals Board granted reconsideration and found that PTP report of November 2008 did not find the applicant PD or indicate the level of PD, the panel QME report of March 2009 found the applicant MMI as of November 2008 and provided a description of impairment factors. The Workers' Compensation Appeals Board did not agree with the WCJ that defendants did not make a reasonable estimate as to PD both on applicant's return to work and the time the PTP issued his final report, indicating that the PTP final report never explicitly declared applicant P and S and did not provide guidance on the extent of PD, thus the Workers' Compensation Appeals Board held that there was no obligation on the defendant's to advance PD until the QME report in March 2009.

The matter was remanded to the WCJ to determine if the defendants complied with the requirements of Labor Code §4061(a) (2) requiring the employer to provide notice to the worker that the amount of PD could not be yet determined as applicant was not yet P and S Labor Code §4650(b) which requires the employer to commence timely payments of PD if defendants can make a reasonable estimate of the PD due to the applicant. Then the defendants at an MSC submitted documentary evidence that established that applicant had had been provided the appropriate notices pursuant to Labor Code §§ 4061(a) (2) and 4650 (b). The WCJ issued the same decision and defendants filed a second Petition for Reconsideration. The WCJ in his decision concluded that the PTP report in November 2008 put the defendants on notice regarding the extent of PD applicant would have had based on findings of loss of range of motion and required the commencement of PD.

The Workers' Compensation Appeals Board cited the case of *Blackledge* (75 Cal. Comp. Cases 613), which described the physician's role in evaluating PD as requiring the medical report state the physician's actual WPI rating for each medical condition and that the doctors exercise his judgment, training, and experience in determining the final WPI. Because the PTP report did not provide a final WPI rating for the condition the Workers' Compensation Appeals Board was not persuaded that defendant's had sufficient notice regarding the extent of PD in order to commence PD advances. The Workers' Compensation Appeals Board granted reconsideration and amended the judges F and A to provide that defendants were entitled to the 15% reduction pursuant to Labor Code §4658(d)(3)(a).

Kruse v. City of San Rafael, (2011) 39 C.W.C.R. 41 (WCAB Panel) (Labor Code §4658(d) adjustment.)

Applicant was unrepresented. He reached agreement for a stipulation to 6%. The WCJ approved the stipulation without the 15% reduction pursuant to Labor Code §4658 (d) (3) (a). The WCJ reasoned that all PD payments were due and payable before the offer of work was made there were no payments remaining to be paid. The Workers' Compensation Appeals Board reversed indicating the first payment of PD is to be made within 14 days after the last payment of PD. Pursuant to Labor Code §4650 (b) when the last payment of TD is made and regardless of whether the extent of PD can be determined at that date the defendant must commence timely payment of PD and must continue to make the PD payments until the employer's reasonable estimate of PD has been paid, or if the amount of PD has been determined until that amount has been paid. Labor Code 4658 (d) (3) (A) provides that if within 60 days of the disability becoming P and S, the employer makes an offer of regular, modified or alternative work in the form and manner prescribed by the AD, each disability payment remaining to be paid from the date of the offer shall be decreased by 15%. In this case the applicant was TTD until December 21, 2008. There was no indication that the injury caused PD until defendants received the report of the treating physician on June 11, 2009.

The Workers' Compensation Appeals Board majority concluded that on the date the defendants sent the written offer all PD remained to be paid within the meaning of Labor Code §4658 (d) (3) (A). As soon as it was determined that the injury had caused PD the PD payments were retroactive to 14 days after the last payment of TD. All PD was payable at the time of the first payment, but the first payment was not payable into there was evidence the injury caused PD. Pursuant to Labor Code 4658 (d) (3) (A) defendant was entitled to a 15% reduction in the PD awarded. The dissent reasoned that making an offer to an employee who has already returned to work mad no sense. She agreed with the WCJ that the employer formally offering work to an employee who is already back at work results in no incentive to the employer. The statute states that each disability payment remaining to be paid at the time of the offer is to be reduced and this per the dissent mean the payments that remain to be paid at the time of the offer is to be reduced, not benefits paid before the offer. Because there had been no weekly payments remaining to be paid after the offer, the offer resulted in no reduction.

Cordova v. State Compensation Insurance Fund, (2011) 39 CWCR 293 (Board panel decision.) (Permanent total disability "in accordance with the facts.")

Applicant sustained work injuries in 2003 which two Qualified Medical Examiners opined resulted in cervical spine fusion and about 40% standard disability under the 1997 rating schedule. Two vocational rehabilitation experts evaluated applicant, one referred to other

medical opinion that applicant was limited to light or sedentary work, the other testified that applicant's injury and lack of transferable skills precluded his ability to perform any job. The WCJ found applicant totally permanently disabled, and that applicant's lack of transferrable skills and lack of ability to speak or understand injury was not apportionable causes of his disability. The WCJ found applicant had no residual earning capacity, was not malingering, and therefore under language in the 1st sentence of Labor Code §4662 a determination of total disability was warranted "in accordance with the facts." Defendant sought reconsideration.

After granting reconsideration, the Appeals Board upheld the determination, and adopted the WCJ's reasoning.

APPORTIONMENT:

Solano County Probation Dept. v. Workers' Compensation Appeals Board (Aguilar), (2011) 76 Cal. Comp. Cases 1 (Court of Appeal not published) (Valid basis for apportionment.)

Applicant sustained injuries to her left shoulder, left elbow, low back and left hip. She was seen by Dr. Peter Mandell, M. D., as an Agreed Medical Examiner on several occasions. Dr. Mandell's initial report was prepared in October 2002. He noted that applicant had pre-existing hip arthritis, but under then applicable apportionment law opined that there was no apportionment to the condition which was not disabling prior to the injury. Dr. Mandell reevaluated applicant after she had hip replacement surgery, and reported in January 2005 that under the new apportionment standards her hip disability was apportionable 2/3rds to cumulative trauma and 1/3rd to pre-existing disease and pathology. After another evaluation in July 2005, Dr. Mandell reported that all of applicant's shoulder disability was a result of cumulative injury. In a further report in May 2006, Dr. Mandell apportioned 10% of applicant's back disability to disease and pathology of obesity; 90% to cumulative injury. A deposition and two subsequent reports resulted in his changing the back disability apportionment to 100% work related. His opinion remained that approximately 33 percent of her left hip disability was the result of obesity and arthritic degeneration. The arthritis in her hip had developed over a period of years. He explained that Aguilar's disability was due in part to arthritis, and that from "a medical standpoint, there's some basis for apportionment." He believed her arthritis led to the need for hip replacement surgery.

The issue of apportionment was submitted, and the WCJ found no apportionment, assuming that if the back apportionment to obesity had become "possible" rather than "medically probable" the apportionment of the hip disability had also been downgraded from probable to possible. The WCJ concluded Dr. Mandell had not sufficiently explained "how and why" the preexisting factors caused disability, as required by Board precedent. The WCJ

did not describe why Dr. Mandell's explanation was insufficient. Defendant sought reconsideration, and the Board denied the petition.

The Court of Appeal granted defendant's petition for writ of review limited to the following issue: Does substantial evidence support the workers' compensation judge's assumption that the agreed medical examiner withdrew his apportionment determination as to respondent Paula Aguilar's left hip injury? The answer is no. After the law on apportionment changed in 2004, Dr. Mandell consistently attributed one-third of Aguilar's left hip disability to nonindustrial causes (arthritis and obesity). He never wavered from that opinion. He never associated that opinion with his opinion on apportionment of Aguilar's spinal disability. The Court found the Board's determination was based on an assumption not supported by the record. The court therefore annulled the decision of the Board and remand for further proceedings consistent with the opinion. None of her shoulder disability was apportioned to disease or pathology. Dr. Mandell discussed his opinions on apportionment at his deposition in August 2007. The June 2008 report the WCJ relied on for his assumption that Dr. Mandell was "remov[ing] obesity" as a cause of disability as to "other body parts" does not support that assumption. Dr. Mandell referred to both obesity and arthritis as nonindustrial causes of Aguilar's left hip disability, so the removal of one factor (obesity) would not eliminate the other factor (arthritis). In reality and in any case, Dr. Mandell's reports and deposition testimony indicate the two factors were connected, with arthritis being the cause of hip injury and obesity being the cause, at least in part, of the arthritis (the arthritis was "due to obesity and things like that"). Finally, the court found Dr. Mandell's reports and testimony adequately explain the basis for his opinions on apportionment under the standards set by this state's courts. "The medical opinion must disclose familiarity with the concepts of apportionment, describe in detail the exact nature of the apportionable disability, and set forth the basis for the opinion, so that the Board can determine whether the physician is properly apportioning under correct legal principles." (*E. L. Yeager v. Workers' Compensation Appeals Board*, (2006) 145 Cal.App.4th at p. 928; 71 Cal. Comp. Cases 1687.) Dr. Mandell documented his review of Aguilar's extensive medical record. The parties explored his opinions on apportionment both by requesting specific reports on apportionment and by questioning him on the concept at his deposition. His reports and testimony reflected that he understood the concepts of apportionment, even as he expressed some antipathy toward apportionment. Dr. Mandell's opinion on apportionment was the only evidence in the record on the issue. There was no basis on which the WCJ could reject it or assume it away. A factual finding or decision is not based on substantial evidence if unreasonable, illogical, arbitrary, improbable, or inequitable considering the entire record and statutory scheme. (*Zenith Ins. Co. v. Workers' Comp. Appeals Board*, (2008) 159 Cal. App. 4th 483, 490; 73 Cal. Comp. Cases 81.) The court annulled the decision of the Board on apportionment of Aguilar's left hip injury and remand the matter to the Board to make a new award and finding on apportionment consistent with this opinion.

State Compensation Insurance Fund v. Dorsett, (2011) 76 Cal. Comp. Cases 1138 (Court of Appeal, 6th Appellate District, unpublished) (Where AME apportioned impairments from multiple injuries, the disabilities are not to be combined avoiding *Benson*.)

Dorsett filed two separate applications to obtain workers' compensation for a specific injury to his cervical spine on March 21, 2000, while working as a glazer for South Valley Glass, Inc. , and a cumulative trauma injury to his cervical spine between November 15, 2002, and June 8, 2004, while working for A-Tek Glass, Inc. (A-Tek). After the first injury applicant had a cervical spine discectomy and fusion; he returned to work with a weight lifting restriction. Both employers were insured for purposes of workers' compensation by State Compensation Insurance Fund. In a report dated 6/5/09, Dr. Izzo, a neurosurgeon and the AME in the CT case, stated:

“There is no question in my mind that had [Dorsett] not had the injury in March of 2000 and had he not had the subsequent surgery that was indicated as a result of that injury and had he not had the unfortunate result of the surgery with subsequent ongoing neck symptoms, the cumulative trauma activities would not be an issue. [¶] The reason for that is that there is absolutely no indication that any of the degenerative changes that were present in his neck . . . were at all symptomatic. [¶] Furthermore, there is no indication on reviewing all the medical records in this case that they would have ever been symptomatic. [¶] The simple fact of the matter is that had the March 2000 injury not occurred, the cumulative trauma injury would not have occurred. In fact, from that point of view, one can very well view this injury (CT injury to June of 2004) as a compensable consequence of the specific injury. [¶] Again this is not my opinion simply based on supposition, but based on the absence of any medical records that would indicate that any of the activities he did subsequent to the March 2000 incident would have led to any symptoms whatsoever.”

In deposition, Dr. Izzo testified that the applicant's overall disability was caused 50% by the specific injury and 50% by the subsequent cumulative injury. The workers' compensation judge determined, based in part on the opinion of an agreed medical evaluator, that Dorsett sustained an “overall combined permanent disability of 100 percent,” and found that “there is only one injury,” and that “there can be no apportionment under *Benson*.” SCIF filed separate petitions for reconsideration on behalf of South Valley and A-Tek.

The Workers' Compensation Appeals Board denied reconsideration. SCIF timely petition for writ of review contending that the Board erred “when—despite the clear statutory command of Labor Code § 4663 and § 4664, and the decision in *Benson* . . . , which interpreted the statutes—it determined that apportionment of permanent disability did not apply.”

SCIF contended that the Board erred when “it determined apportionment of permanent disability did not apply” in this case. SCIF argues that, because Dr. Izzo clearly found two injuries, and he was able to apportion the permanent disability between the two injuries, the WCJ erred under sections 4663 and 4664 in making a joint and several 100 percent permanent disability award against the two employers. Dorsett contends that SCIF’s argument “does not consider the exception outlined in *Benson* . . . and failed to consider that the AME found one injury to be a compensable consequence of the other, and thus the injuries are not in fact ‘separate’ or ‘distinct.’ ” Dorsett argues that one injury can be a compensable consequence of another injury, and that the employers failed in their burden of proof on the issue of apportionment. Sections 4663 and 4664 were enacted as part of Senate Bill 899 (2003-2004 Reg. Session) (SB 899), an omnibus bill to restructure California’s workers’ compensation system. Before the enactment of SB 899, the general rule was that “apportionment was ‘concerned with the disability, not its cause or pathology.’ [Citation.]” (*Marsh v. Workers’ Compensation Appeals Board*, (2005) 130 Cal. App. 4th 906, 912 (*Marsh*); see also *Benson*, supra, 170 Cal.App.4th at pp. 1545, 1557.) “Apportionment based on causation was prohibited. (*Brodie*, supra, 40 Cal. 4th at p. 1326.) “This rule left employers liable for any portion of a disability that would not have occurred but for the current industrial cause” “[I]n case after case courts properly rejected apportionment of a single disability with multiple causes and, employees were granted “wide latitude to disprove apportionment based on prior permanent disability awards by demonstrating that they had substantially rehabilitated the injury.

The court of Appeal held that the WCJ must make an apportionment determination in this case and the court annulled the Board’s order and remand the matter for further proceedings.

“The plain language of new sections 4663 and 4664 demonstrates they were intended to reverse these features” of the former workers’ compensation system. (*Brodie*, supra, 40 Cal. 4th at p. 1327.) Apportionment is now “based on causation.” (§ 4663, subd. (a).) Under SB 899, “the new approach to apportionment is to look at the current disability and parcel out its causative sources—nonindustrial, prior industrial, current industrial—and decide the amount directly caused by the current industrial source. This approach requires thorough consideration of past injuries, not disregard of them.” (*Brodie*, supra, 40 Cal. 4th at p. 1328.) The “clear intent” of the Legislature in enacting SB 899 was “to charge employers only with that percentage of permanent disability directly caused by the current industrial injury.” (*Brodie*, supra, 40 Cal. 4th at p. 1332; see also *Marsh*, supra, 130 Cal. App. 4th at p. 912.) Therefore, evaluating physicians, the WCJ, and the Board must “make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries.” (§ 4663, subd. (c); see also *Benson*, supra, 170 Cal. App. 4th at p. 1550, fn. 13.)

In *Wilkinson v. Workers' Comp. Appeals Bd.*, (1977) 19 Cal.3d 491, the Supreme Court held that “whenever a worker . . . sustains successive injuries to the same part of his body and these injuries become permanent at the same time, the worker is entitled to an award based on the combined disability.” (Id. at p. 494.) The *Wilkinson* court concluded that when two separate work-related injuries become permanent at the same time, neither permanent disability is previous to the other and the employee therefore is entitled to a single permanent disability rating. (Id. at p. 497.) However, the Court of Appeal in *Benson* concluded that “[t]he clear change in the statutory language” of sections 4663 and 4664 as a result of SB 899 indicates a Legislative intent “to invalidate *Wilkinson*.” (*Benson*, supra, 170 Cal.App.4th at p. 1550.) Now, “the plain language of section 4663, subdivision (c), read in conjunction with the statutory scheme as a whole, ‘specifically requires a physician to determine what percentage of disability was caused by each industrial injury, regardless of whether any particular industrial injury occurred before or after any other particular industrial injury or injuries.’ ” (*Benson*, supra, at p. 1552.)

“[T]here may be limited circumstances, not present here, when the evaluating physician cannot parcel out, with reasonable medical probability, the approximate percentages to which each distinct industrial injury causally contributed to the employee’s overall permanent disability. In such limited circumstances, when the employer has failed to meet its burden of proof, a combined award of permanent disability may still be justified. (See § 4663, subd. (c); *Kopping v. Workers’ Compensation Appeals Board*, (2005) 142 Cal.App.4th 1099 at 1115, ‘the burden of proving apportionment falls on the employer because it is the employer that benefits from apportionment’[.]” (*Benson*, supra, 170 Cal.App.4th at p. 1560, see also id. at p. 1541, fn. 3.)

The WCJ and the Board in the case before us found that there could be no apportionment pursuant to *Benson* because here, unlike in *Benson*, the evaluating physician found that the second industrial injury was a compensable consequence of the first industrial injury. The Court of Appeal disagreed with the Board’s finding. Labor Code §5302 states that decisions and awards of the Board shall be presumed to be reasonable and lawful. However, pursuant to SB 899, *Brodie* and *Benson*, successive injuries to the same body part that become permanent and stationary at the same time can no longer be rated as a single injury. Rather, successive injuries must be rated separately, except when physicians cannot parcel out the causation of disability. Absent an ambiguity in the statutory scheme, the court may not rely on section 5302’s directive to extend the benefits awarded to the injured worker here. (*Brodie*, supra, 40 Cal.4th at p. 1332.) While the legislative policy set forth in SB 899 treats Dorsett less favorably than if he had sustained a single injury with the same level of disability, “we interpret the law; we do not write it.” (*Barr v. Workers’ Compensation Appeals Board*, (2008) 164 Cal.App.4th 173, 178.)

Here, the AME stated that Dorsett’s two injuries became permanent and stationary at the same time and that his “current level of permanent disability—whatever that level may be—is

apportioned 50 percent to the specific injury and 50 percent to the cumulative trauma injury.” “The doctor made a determination based on his medical expertise of the approximate percentage of permanent disability caused by [the employee’s two injuries]. Section 4663, subdivision (c), requires no more.” (*E.L. Yeager Construction v. Workers’ Compensation Appeals Board*. (2006) 145 Cal. App. 4th 922, 930.) Therefore, based on the testimony of the AME, the successive injuries can be rated separately and Dorsett’s joint and several award of 100 percent permanent disability must be annulled. Upon remand, the WCJ must make an apportionment determination by finding what approximate percentage of Dorsett’s permanent disability was caused by the direct result of the cumulative trauma injury and what approximate percentage of the permanent disability was caused by other factors, including his prior specific industrial injury. (Labor Code §4663, subd. (c).)

The order denying reconsideration is annulled, and the matter is remanded to the Board with directions to order the WCJ to make an award consistent with this opinion.

Salit v. Workers’ Compensation Appeals Board, (2011) 76Cal. Comp. Cases 1129 ; 13 WCAB Rptr. 13339 (ADJ1170386/ADJ465830) (Court of Appeal, 2nd Appellate District, unpublished.) (Error in apportionment determination.)

Applicant, a police officer, sustained injuries to his left knee and back in 1990, and to his right shoulder and back in 1991. He was awarded 24.1% permanent disability after apportionment. In 1995 applicant sustained a TMJ syndrome, hearing loss, fibromyalgia, neck, and upper extremities injury, and allegedly irritable bowel syndrome (IBS). Applicant retired and became an IT tech for Alpha Industries. He claimed cumulative injury to 7/28/2003 in Alpha’s employment to his neck, back and upper extremities. The 1995 and 2003 cases were consolidated. After trial second rating instructions brought a recommended rating of 42½% PD after post SB899 apportionment. The WCJ found 42½% PD after apportionment, and found the IBS non-work related. Applicant sought reconsideration contenting that the WCJ erred in not finding irritable bowel syndrome or gastrointestinal industrial injury; and in apportioning twice for the same prior injuries or conditions; that the findings regarding PD and apportionment were not otherwise justified by the evidence; and that defendant failed to meet its burden under *Kopping*.

The Workers’ Compensation Appeals Board denied reconsideration. Applicant filed a Petition for Writ of Review.

The Court annulled the WCAB’s decision, concluding that the finding that applicant did not sustain industrial IBS was not supported by substantial evidence, and that the apportionment findings related to applicant’s fibromyalgia injury were also not supported by substantial evidence.

In reversing the determination that applicant did not sustain industrial injury in the form of IBS, the Court stated, among other things: When a party testifies to facts favorable to his own position and any contradictory evidence is within the ability of the opposing party to produce, the latter party's failure to bring forth such evidence will require acceptance of the uncontradicted testimony unless there is some other rational basis for disbelieving it. (*Braewood Convalescent Hospital v. Workers' Compensation Appeals Board*, (1983) 34 Cal. 3d 159, 167.) In this case the court did not find a rational basis for disbelieving either petitioner's testimony or the reports of two physicians, Drs. Levine and Leoni. Because evidence that petitioner's IBS injury was industrial was uncontradicted at trial, the WCJ's finding of no industrial IBS injury is not based on substantial evidence."

With regard to apportionment, the Court concluded:

"A review of the entire record shows no evidence to support apportioning 15.5% to pre-1995 injuries, in addition to apportioning 25% to these same injuries. The WCJ, however, instructed the rater to make this additional apportionment. The WCJ's opinion does not explain how she arrived at the 15.5% number other than to say that she relied on Dr. Stoltz's medical report from 1993. However, at the time of Dr. Stoltz's report, petitioner had not been diagnosed with fibromyalgia. Moreover, Dr. Stoltz's report does not reflect an opinion that there should be an apportionment of 7.75% for both the neck and the back. The stipulated award reflects that, based on Dr. Stoltz's report, petitioner's overall back disability rated only 8%. It is unclear from the record how Dr. Stoltz's report supports an apportionment of 7.75% each for neck and back injuries.

"Dr. Levine's report incorporated Dr. Stoltz's report in his apportionment of 25% to the prior injuries, 65% to the October 11, 1995 injury, and 10% to subsequent injuries. The record does not provide any basis for an additional 15.5% apportionment to injuries that occurred prior to 1995. On matters of scientific knowledge, the board may not impermissibly substitute its judgment for that of a medical expert. (*E.L. Yeager Construction v. Workers' Compensation Appeals Board*. (2006) 145 Cal. App. 4th 922, 930.) Accordingly, we conclude that the additional 15.5% apportionment is not supported by substantial evidence."

Finally, the Court rejected applicant's contention that the opinions of his own treating physicians rather than the opinions of defendant's QMEs should have been relied upon because his treating physicians had more familiarity with his condition because they had treated him frequently over the course of many years. The Court stated:

"In order to constitute substantial evidence, a medical opinion must be predicated on reasonable medical probability. (*Andersen*, supra, 149 Cal. App. 4th at p. 1381.) It is not substantial evidence if it is based on facts no longer germane, on inadequate medical histories or examinations, on incorrect legal theories, or on surmise, speculation, conjecture, or guess. (*Rosas v. Workers' Compensation Appeals Board*, (1993) 16 Cal.

App. 4th 1692, 1702.) Further, the report must set forth the reasoning behind the physician's opinion, not merely his or her conclusions. (*Andersen*, supra, 149 Cal. App. 4th at p. 1381.) The fact that a physician has limited familiarity with the patient's condition as compared to another physician does not render his or her opinion insubstantial medical evidence. We do not hold otherwise."

Garvey v. City of Los Angeles, (2011) 39 C.W.C.R. 175 (Board panel) (Anti-attribution precludes §4663 apportionment, but not §4664(c) 100% to a body region limitation.)

Applicant a police officer for the City of Los Angeles sustained an admitted CT injury from June 8, 1996 to February 7, 2007 to the heart and hypertension. The applicant had a prior claim for the heart with the City of Los Angeles which had been settled by a stipulated award of 30% PD for the heart based on the old PD schedule. Applicant filed a petition to reopen that case. The parties in the latter case used an AME who found 45 % WPI for the hypertension, 25% PD for coronary artery disease and 10% WPI for cardiac arrhythmia. On apportionment the AME apportioned 30% percent of the current disability for the heart and hypertension to the CT and 70% to the prior injury. All the disability for the cardiac arrhythmia was apportioned to the latter CT injury. The AME also came up with an alternative method of apportionment by converting the old injury PD to AMA impairment.

The WCJ rejected the AME's second method as speculative. The WCJ based on the AME issued an award for 47% PD after apportionment of 70% of the heart and hypertension to the prior injury. The WCJ found over all current PD based on the new schedule at 88% PD. The applicant filed a petition for reconsideration.

The WCAB reversed the WCJ and remanded the matter back to the trial level. The WCAB indicated the case involved Labor Code §3212.5 presumptive injuries to the heart and neither party challenged that issue. Therefore the WCAB ruled that no Labor Code §4663 apportionment applies to a presumptive injury to the heart pursuant to Labor Code §3212.5 because of the anti-attribution clause of that section. The WCAB concluded the WCJ had erred by apportioning pursuant to Labor Code §4663. The WCAB stated that for apportionment pursuant to Labor Code §4664 and the *Kopping* case (71 Cal. Comp. Cases 1229) the defendant has the burden of proof to prove that the applicant had a final award of PD and that the PD overlaps the impairment from the current injury. The panel concluded citing the *Minvielle* case (75 Cal. Comp. Cases 896) that when the injuries use different standards for determining PD (old schedule new schedule) the defendant fails to prove overlap. The WCAB concluded in this case defendants failed to prove overlap and therefore apportionment pursuant to Labor Code §4664 was not proper. The WCAB concluded that although no apportionment should be allowed to the prior CT injury, the PD award could not be increased at present because the subsequent cardiac award, when combined with the prior cardiac award, totaled more 100 % PD for the same body part, a result prohibited by Labor Code §4664 (c). Since the

issue had not been litigated, any finding on PD and attorney fees must be deferred. The WCAB returned the matter to the trial level, stating that if the parties cannot settle, the trial judges must address application of Labor Code §4664 (c) to the facts of this case.

City of Santa Clara v. Workers' Compensation Appeals Board (Sanchez), (2011) 76 Cal. Comp. Cases 799 (Writ Denied) (No apportionment or 4664(c) where 100% disability is presumed under §4662(d).)

Applicant while employed as a heavy equipment operator suffered a CT injury to his spine and both knees ending 1-20-2008 and a specific injury to his right knee on 9-14-2004. Applicant had a bilateral total knee replacement on 1-30-2008 and suffered a stroke as a result of complications from the surgical procedure. Applicant filed applications for both injuries and for SIBTF benefits. Applicant stipulated to a prior award of 18.5% PD for an injury on 1-9-95 to his left knee and sustained injury to his back on 8-22-95 also causing PD of 18.5%. The WCJ following trial found TPD of 100% in accordance with Labor Code §4662(d). The WCJ found that, based on the fact PD was found based on the conclusive presumption of total disability of Labor Code §4662(d), no apportionment was indicated pursuant to Labor Code §§4663 or 4664 or the *Benson* case (74 Cal. Comp. Cases 113). Applicant's request for SIBTF benefits was also denied. Defendant filed a Petition for Reconsideration. The WCJ recommend that reconsideration be denied. The defendants did not dispute that applicant was 100 permanently disabled as a result of the stroke, but argued they were entitled to apportionment pursuant to Labor Code §§4663, 4664, and the *Benson* case.

The WCAB in a split decision agreed with the WCJ. Citing the case of *Dragomir-Tremoureaux* (71 Cal. Comp. Cases 638 W/D) the WCJ and the WCAB concluded that when the conclusive presumption of Labor Code §4662(b) applies that presumption precludes apportionment of any kind including apportioning to a prior award under Labor Code §4664(b). The WCAB went on that their conclusion that evidence of prior disability under Labor Code §4664(b) cannot rebut the presumption of permanent total disability of Labor Code §4662(b) is supported by the plain language of Labor Code §4664(c) (1), which precludes the accumulation of all PD awards with respect to any one region of the body from exceeding 100% over the injured employees lifetime unless the employees injury or illness is presumed to total pursuant to Labor Code §4662. Therefore, in this case because the applicant is presumed totally disabled pursuant to Labor Code §4662(b), the lifetime accumulation of awards may exceed 100% PD. The WCAB went on to indicate that they agreed with the WCJ that the Labor Code §4662 presumption of total disability in itself precluded any type of apportionment. The WCAB noted that the last sentence of Labor Code §4462's conclusive presumption which states that in all other cases, permanent total disability shall be determined in accordance with fact, precludes Labor Code §4662 cases from the evidentiary requirements of Labor Code §4663, which requires evidence of the causation of permanent disability. Labor

Code §4662 creates a conclusive presumption that it was caused by the injury. The therefore upheld the decision of the WCJ.

The dissenting opinion agreed in this case the applicant is entitled to an unapportioned award. The dissent stated they did not agree with the majority that an overall finding of PD pursuant to Labor Code §4662 is per se unapportionable. Labor Code §4662 does not state that the listed disabilities are not subject of any type of legal apportionment. The Dissent would conclude just as in the normal rating schedule applicable to most injuries, nothing in the Labor Code §4662 suggests the overall rating are not subject to apportionment. The dissent agreed that a finding or total disability pursuant to Labor Code §4662 is exempt from Labor Code §4664 (c)(1) limit pursuant to the plain the language in the statute. However apportionment pursuant to Labor Code §4664(b) is completely distinct form Labor Code §4664(c)(1) limit. Had the legislature intended to exempt injuries covered by §34662 from Labor Code §4664(b), it would have created an express exception, just as it did for Labor Code §4664(c)(1) limit. Labor Code §4663 expressly exempts a number of injuries form its provisions, however it does not expressly exempt injuries covered by Labor Code §4662. The dissent indicated he would depart form the majority and find that in the proper case, overall PD of total disability pursuant to Labor Code §4662 may be apportioned pursuant to both Labor Code §§4663 and 4664. In this case the dissent agreed with the conclusion of no apportionment of the majority but based on the fact defendant failed to meet their burden of proof of apportionment pursuant to Labor Code §§663 and 3664. The Writ was denied.

State Compensation Insurance Fund v. Workers' Compensation Appeals Board (Dunehew), (2011) 76 Cal. Comp. Cases 1251 (Writ denied) (Where permanent disability is apportioned among successive injuries, advances made for PPD in one case may not be creditable to permanent disability owed in other cases.)

Applicant sustained musculoskeletal injuries to his back, both knees, and other parts on March 31, 2003, cumulatively through 2000, and cumulatively through June 30, 2007. Defendant made permanent disability advances totaling \$11,447.40 on the 2003 specific injury. By a second award, it was found that applicant had sustained permanent partial disability entitling him to indemnity totaling \$6,336.25 on the 203 injury, \$4,830 on the 2007 injury, and \$8,040 on the 2000 injury. The WCJ allowed credit for the \$11,447.40 advances against the permanent disability awarded in the 2003 and 2007 injury. Applicant sought reconsideration

Applicant contended that allowing credit for disability indemnity advances for one injury against compensation payable for another injury contravened the holding in *Benson v. Workers' Compensation Appeals Board*, (2009) 74 Cal. Comp Cases 113. Defendant contended that allowing the credit for advances against both its liability for indemnity in either or both injuries did not violate *Benson* were the WCJ made separate findings of fact and awards for each injury. The WCJ recommended reconsideration be denied, pointing out that

Labor Code Section 4909 did not limit credit for payments made by or on behalf of the employer against a particular injury.

The Appeals Board granted reconsideration and in a split panel decision held in a split decision that the credit afforded by Labor Code Section 4909 is discretionary. [Citations omitted.] Here application of the holding in *Benson* resulted in a division of the permanent disability indemnity among three injuries, and a smaller sum of indemnity that if the overall disability had been awarded under *Wilkinson*. Since defendant ‘received a benefit from this change in the law it would be inequitable for defendant

“[T]o obtain the benefit of the separation of the three injuries for purposes of calculating the permanent disability while allowing defendant to essentially merge the cases for purposes of permanent disability advances.

“Furthermore, allowing defendant a credit would be destructive of the purpose of the permanent disability award for applicant’s 2007 injury....[Because the] advances were made prior to applicant’s 2007 cumulative trauma injury.” (*State Compensation Insurance Fund v. Workers’ Compensation Appeals Board (Dunehew)*, (2011) 76 Cal. Comp. Cases 1251, at 1253-1254.)

Defendant sought reconsideration of the decision, but its petition was denied by a split panel. Defendant’s petition for writ of review was denied.

Grimaldi v. City of Fullerton, (2011) 39 CWCR 268 (WCAB Panel) (Credit for overpayment against other species of benefits)

Applicant injured his right knee on October 13, 20005. Defendants advance PD of \$10,411.23 based on the report of the QME, Dr. Hunt which rated 18% PD. Applicant’s knee gave out and he sustained a second compensable consequence injury to the tight knee. After the parties could not agree on an AME the applicant obtained a QME report that rated 1% WPI.

The parties came to hearing and stipulated that PPD in the amount of \$10, 411.23 had been advanced, and that the injury caused 2% PPD and need for further medical treatment. They also stipulated that defendant was entitled to a credit of \$4,545.62 (one-half the credit claimed). The WCJ awarded compensation and allowed the credit. The applicant filed a petition for reconsideration.

The WCJ indicated in his report and Recommendation that allowance of the credit is discretionary. The WCJ indicated the test in allowing a credit for PD against future medical treatment is a balancing of the fact the defendant advanced the PD with the fact the applicant might require the future medical treatment (this case surgery).

The WCAB denied reconsideration with one commissioner dissenting. The dissent indicated that the allowance of the credit is discretionary if the benefits paid were not in fact

due and payable. The dissent citing the leading case on this issue *Maples* (45 CCC 1106), the commissioner opined that credit need not be allowed for on specie of benefit for overpayment of another specie of benefit if the allowance would defeat the public policy purpose of the benefit against which the credit it proposed to be allowed, or if the overpayments resulted from inept administration of the claim. The employer must provide medical treatment to cure or relieve for the effects of the injury. Credit against future medical treatment may be denied if the applicant did not request the advances for which defendant is seeking credit and the evidence regarding the extent of PD is uncertain. (*City of Long Beach (Schaich)*, 63 CCC 1067 (Writ denied). Credit can also be denied if the future benefits are anticipated and the overpayment was received without fault on the worker's part. (Act 1 (Denny) (72 CCC 369 W/D) Even if the credit is allowed against another benefit, it may be denied against future medical benefits as contrary to the public purpose of LC 4600.(*Bowie*,65 CCC 59 W/D). The dissent would have found that the applicant was not at fault in the overpayment and to allow the credit would in effect deny him anticipated future medical treatment.

MEDICAL TREATMENT, ACOEM/MTUS, UTILIZATOIN REVIEW, MPNs:

State Farm Insurance Co. v. Workers' Compensation Appeals Board (Apparicio), (2011) 192 Cal. App. 4th 51; 76 Cal. Comp. Cases 69 (Medical Treatment—home care; *ex parte* communication with regular physician)

Applicant Francisca Apparicio had previously been awarded 100% permanent disability as the result of industrial injuries. Her husband, Carl Pearson, was involved in providing attendant home healthcare. Mr. Pearson filed a lien requesting reimbursement for providing "medical treatment" to his wife in the form of attendant home healthcare. Defendant disputed the lien and the matter went to trial. The WCJ requested further development of the record and appointed a physician to evaluate the home health care needs of the applicant.

Contrary to the requirements of *Alvarez v. WCAB*, (2010) 75 Cal Comp. Cases 817 or 397 , regarding *ex parte* communications, Mr. Pearson contacted the appointed evaluating physician *ex parte* and provided additional documentation and medical reports in support of his lien claim, without providing notice to the defendant. The evaluating physician was later deposed and offered the opinion that the applicant should be monitored and assisted 24 hours a day. Defendant objected to the report on the grounds that the applicant was not receiving assistance in the form of "medical treatment" during the entire 24 hours; in fact the evidence supported the contention that the applicant was receiving assistance in the form of medical treatment only 2.75 hours per day.

During further proceedings the WCJ awarded the lien claimant/husband approximately \$1.5 million as reimbursement for 24-hour home healthcare between 2003 and 2009 at the rate of \$30.00 per hour, based on an upper range of evidence regarding LVN rates.

Defendant appealed, and the WCAB denied reconsideration. Defendant then sought a writ.

The Second Appellate District concluded that the rate of \$30.00 per hour seven days per week was not justified and was an act in excess of the powers of the Appeals Board. Moreover, the calculation of \$30.00 per hour at an LVN rate was not reasonable. The matter was remanded to the WCAB to identify which caregiver services being provided by the applicant's husband were "medical treatment" within the meaning of Labor Code §4600.

Finally, because of the ex parte communication with the evaluating physician appointed by the WCAB, the appellate court affirmed the *Alvarez* standard that ex parte communication with an evaluating physician is strictly prohibited, ordered the report be stricken and that a new physician be appointed in order to evaluate the appropriate caregiver needs of the applicant.

Valdez v. Warehouse Services Zurich North America, by ESIS, (2011) 76 Cal. Comp. Cases 330 (WCAB En Banc) (Admissibility of non-MPN Medical Reports where applicant required to treat within MPN.)

Applicant sustained injury to her neck, back, right hip, right lower extremity, right ankle, right foot, and bilateral knees AOE-COE on October 7, 2009. She was referred to Dr. Nagatomo, a physician in defendant's Medical Provider Network (MPN), and treated there for three weeks. After October 31, 2009, applicant commenced treatment with a non-MPN physician, Dr. Nario, on referral from her attorney. On July 22, 2010 the case was tried and the issue of temporary disability from October 7, 2009 to date and continuing submitted, lien of Employment Development Department, and defendant's objection consideration of reports of applicant's treatment outside the MPN. Applicant testified that she left the MPN physician because that treatment was not helping, and that she did not consult with defendant's adjuster about the change of physician. The WCJ deferred determination of the issue of liability for the cost of the treatment outside the MPN. The WCJ found that the issue of treatment outside the MPN was unrelated to the issue of temporary disability, and relying on the opinions of Dr. Nario found applicant's condition to be continuing temporary disability. Defendant sought reconsideration, again contending that the non-MPN medical reports were inadmissible.

The Appeals Board granted defendant's petition for reconsideration, initially to allow time to study the record and applicable law. Defendant contends, however, that non-MPN medical reports are inadmissible and not entitled to be relied upon for determination of any issue. The Workers' Compensation Appeals Board then issued its En Banc decision holding that where unauthorized treatment is obtained outside a validly established and properly noticed MPN, reports from the non-MPN doctors are inadmissible, and therefore may not be relied upon, and that defendant is not liable for the cost of the non-MPN reports. It noted that the applicant was sent for medical treatment to the employer's MPN, where she was seen by Dr. Nagamoto, who treated her from approximately October 9, 2009 to October 31, 2009. Applicant never spoke to the claims examiner or otherwise notified defendant about this complaint concerning Dr. Nagamoto's treatment. She never requested a second MPN physician, nor did she select

another physician from within the MPN. However the record did not establish that the employer had complied with requirements that the employer notify the injured employee of her right to change physician with the MPN or how to engage the second or third opinion process, or reach independent medical review.

Labor Code §4616.6 precludes the admissibility of non-MPN medical reports with respect to disputed treatment and diagnosis issues, i.e., “any controversy arising out of this article.” Here, for unknown reasons, the applicant almost immediately chose to go outside the MPN and seek treatment in violation of the MPN statutes and procedures. The applicant should have either changed treating physicians within the MPN and/or sought the opinion of a second or third MPN physician, etc. Therefore, the non-MPN physician is not authorized to be a PTP, and accordingly, is not authorized to report or render an opinion on “medical issues necessary to determine the employee’s eligibility for compensation” under §4061.5 and AD Rule 9785(d). (Cal. Code Regs., tit. 8, § 9785(d).) Subsequently, the WCJ awarded compensation, i.e., temporary disability indemnity, based on the reports of the unauthorized, non-MPN physician.

Moreover, (b) for disputes involving temporary and/or permanent disability, neither an employee nor an employer are allowed to unilaterally seek a medical opinion to resolve the dispute, but must proceed under Labor Code §§4061 and 4062 to select an Agreed Medical Examiner or Qualified Medical Examiner. Accordingly, the non-MPN reports are not admissible to determine an applicant’s eligibility for compensation, e.g., temporary disability indemnity. Furthermore, the Workers’ Compensation Appeals Board concluded that neither §4605 nor §5703(a) justifies the admission of reports from non-MPN doctors where treatment was improperly obtained outside the MPN. The reports of non-MPN physicians are inadmissible and therefore may not be relied on to award compensation.

The Board concluded that Labor Code §4605 does not justify the admission of unauthorized non-MPN medical reports. The Workers’ Compensation Appeals Board wrote that the fact that Labor Code §5703(a) is discretionary, i.e., “[t]he appeals board may receive as evidence...” (italics added), “we also conclude that unauthorized non-MPN medical reports are not admissible under §5703(a). That is, our discretion should not be used to admit medical reports or testimony in lieu of such reports resulting from an unauthorized departure outside the MPN.

The majority noted that the concurring and dissenting opinion of Commissioner Caplane asserts that our decision effectively deprives injured workers from receiving compensation in these circumstances. On the contrary, it is those applicants who have chosen to disregard a validly established and properly noticed MPN, despite the many options to change treating physicians and challenge diagnosis or treatment determinations within the MPN, and to dispute temporary or permanent disability opinions under §§ 4061 and 4062 outside the MPN, who

have removed themselves from the benefits provided by the Labor Code. B. Where unauthorized treatment was obtained outside the MPN, a defendant is not liable for the cost of the inadmissible reports from non-MPN physicians

The Workers' Compensation Appeals Board had held in *Knight v. United Parcel Service*, (2006) 71 Cal. Comp. Cases at p. 1435 WCAB en banc), that the defendant's failure to provide an injured employee with notice of his or her rights under the MPN which resulted in a neglect or refusal to provide reasonable medical treatment, rendered the defendant liable for the reasonable medical treatment self-procured by the employee. In *Knight*, the applicant testified that he never received written notice about the MPN and there was no written notice in evidence. In addition, the applicant was never provided notice of whether an MPN physician had been designated as his PTP, nor was he notified of his rights to be treated by an MPN physician of his choice after his first visit, and to obtain second and third opinions. Conversely, where there has been no neglect or refusal to provide reasonable medical treatment, a defendant is not liable for the medical treatment procured outside the MPN. This is consistent with §4605, which provides: "Nothing contained in this chapter shall limit the right of the employee to provide, at his own expense, a consulting or any attending physicians whom he desires." (Emphasis added.)

Whether the defendant had a validly established MPN and whether it provided the required MPN notices to the applicant are highly relevant to determine the propriety of the applicant seeking treatment outside the MPN and the reliance on a non-MPN physician to award temporary disability benefits. Accordingly, based on the WCJ's deferral of this issue, his decision must be rescinded, and this matter remanded to the trial level for further proceedings consistent with this opinion.

Finally, the Workers' Compensation Appeals Board noted that should further proceedings determine the existence of a validly established and properly noticed MPN, then the applicant should comply with the applicable MPN provisions and resolve any dispute concerning temporary and/or permanent disability under the procedures set forth in Labor Code §4061 and 4062. On the other hand, should the evidence fail to determine the existence of a validly established and properly noticed MPN, then the applicant may continue to treat outside the MPN until the defendant is in compliance with the MPN regulations (see *Babbit v. Ow Jing dba National Market*, (2007) 72 Cal. Comp. Cases 70 (Appeals Board en banc)) and the WCJ assigned to this matter may award temporary disability benefits on the present record, or in his or her discretion, may allow defendant to object to the report in question under §4062(a) should it be determined under the circumstances of this case that "good cause" exists to extend the time limits of that section. Of course, any award of temporary disability must be supported by substantial medical evidence, and if such evidence is lacking, the medical record should be further developed as expeditiously as possible.

Valdez v. Warehouse Services Zurich North America, by ESIS (II) (2011) 76 Cal. Comp. Cases 970 (WCAB En Banc) (Admissibility of non-MPN Medical Reports where applicant required to treat within MPN.)

On May 16, 2011, applicant filed a timely petition for reconsideration of the en banc decision. On July 14, 2011, the Appeals Board granted reconsideration of the en banc decision issued in this matter on April 20, 2011, to further study the factual and legal issues in this case. On September 27, 2011 the Appeals Board issued a further en banc decision affirming the decision above. The Board reiterated that that Labor Code §4616.6, by its terms, specifically precludes the admissibility of non-MPN medical reports only with respect to disputed treatment and diagnosis issues. It noted that this specific prohibition extended to benefit issues related to diagnosis issues, stating “a report from a non-MPN treating physician finding an applicant to be temporarily disabled, for example, based on a different diagnosis from the MPN physician, should not be admissible under section 4616.6.” (Footnote 4.) The more general exclusion is based on the statutory requirement that an injured worker utilize the physician selection procedures contained in the [MPN] network pursuant to [section] 4616 before engaging a non-MPN treating physician.

Scudder v. Verizon California, (2011) 39 C.W.C.R. 72 (WCAB Panel) (A pre-designated personal physician of choice outside the MPN may refer an injury for other treatment outside the MPN, but injured’ s attorney may not.)

Applicant was injured on February 14, 2006. Although the defendants had an MPN the applicant was initially treated by his personal physician who he had previously designated to be his treating physician pursuant to Labor Code §4 600(d). After two visits his personal physician referred the applicant to Dr. Jackson. While applicant was treating with Dr. Jackson he developed deep vein thrombosis and Dr. Jackson referred him to Dr. Majcher, a QME in internal medicine and cardiovascular disease. Applicant was examined by a QME in orthopedics whom applicant selected from a panel. Applicant then obtained an attorney. The attorney designated Dr. Sobol as the PTP. Dr. Sobol, a spinal specialist, referred applicant to Dr. Lipper a QME in internal medicine. The matter went to trial on the issues of PD and further medical treatment. Defendants objected to the receipt of the medical reports of Dr. Sobol and Lipper. The WCJ issued Findings and Award determining that applicant had sustained 65% permanent disability, that applicant was in of further medical treatment, that applicant was entitled to reimburse for self-procured medical treatment, and that it was permissible for the applicant to change treating physicians pursuant to AD rule 9780. Defendant filed a petition for reconsideration. In his report and recommendation on reconsideration the WCJ indicated that he admitted the reports of Dr. Sobol and Dr. Lipper and had relied on those reports of the PD award.

The Workers' Compensation Appeals Board granted reconsideration and ruled the medical reports of Dr. Sobol and Lipper were inadmissible and rescinded the findings based on those reports. The Workers' Compensation Appeals Board noted that Labor Code §4600(c) provides that unless the employer has established and MPN as provided for in Labor Code §4616, the injured worker may be treated by a physician of his or her choice after 30 days from the date of injury. Labor Code §4600(d) (6) provides that the applicant is entitled to all appropriate referrals by the personal physician to other physicians within the non-occupational health plan. AD rule 9780.1(c) provides that when an employer has an MPN pursuant to Labor Code §4616, an employee's pre-designation shall be valid and the employee shall not be subject to the MPN. Where an employee has made a valid pre-designation and the employer has an MPN, any **referral to another physician** for other treatment need not be to an MPN physician (AD rule 9780.1(d)). In this case defendant had an MPN, applicant pre-designated his personal physician, and **his personal physician had not referred the applicant to either Dr. Sobol or Dr. Lipper**. The referral to Dr. Sobol was made by the applicant's attorney and invalid pursuant to Labor Code §4600(d) (6).

The reports of both Dr. Sobol and Dr. Lipper were therefore inadmissible in evidence. The Workers' Compensation Appeals Board concluded that Labor Code §4600(c), which provides that an injured employee may be treated by a physician of his or her choice, on, applies if the employer does not have a valid MPN. In this case the applicant was entitled to have his personal physician refer him to an MPN which was properly done when the personal physician referred the applicant to Dr. Jackson. The Workers' Compensation Appeals Board noted that AD rule 9780.1(d) could be read as allowing any referral to another physician outside the MPN, but that reading would be inconsistent with the express wording of Labor Code §4600(d)(6). To the extent a rule contradicts a statute under which it is promulgated it is invalid. (*Boehm & Assoc. v. Workers' Compensation Appeals Board (Lopez)*, 76 Cal. App. 4th 513; 64 Cal. Comp. Cases 1350). The Workers' Compensation Appeals Board granted reconsideration amended the findings and award to defer the issue of PD, excluded the reports of Dr. Sobol and Lipper and remanded the matter to the trial level for further proceedings.

Croushorn v. Workers' Compensation Appeals Board, (2011) 76 Cal. Comp. Cases 674 (Writ Denied) (Scope of home modification and in vitro fertilization of spouse as required medical treatment.)

Applicant sustained industrial injury resulting in paraplegia. The case-in-chief settled by stipulation to 100% PD and future medical care. Applicant sought to be reimbursed for remodeling expenses related to his vacation home (wheelchair access and elevator) in the amount of \$83, 396.6. The applicant also sought reimbursement for the cost of in vitro fertilization in the amount of \$70, 504 and the cost of further medical and psychiatric care.

After a hearing the WCJ awarded the applicant both the expenses for medication to the vacation home and for the in vitro fertilization. Defendants filed for reconsideration.

The WCAB granted reconsideration and remanded the matter to the trial level for further proceedings. The WCAB noted that it was undisputed that as a result of the industrial injury the applicant and his wife could only conceive children through the use of in vitro fertilization. The WCAB further noted that defendants had provided for the modification of applicants prior and present residence. The applicant had incurred expenses in remodeling his vacation home that was not being paid for by defendants. The WCAB indicated that Labor Code §4600 includes certain specific enumerated services and equipment. The pointed out that the section was inclusive not exclusive therefore the section covers other medical care not specifically enumerated. The WCAB indicated that medical treatment has been held to include bookkeeping services and specially-equipped vehicles. That pursuant to Labor Code §4600 medical treatment that is reasonably required to cure or relieve for the effects of the industrial injury is based upon the guidelines adopted by the Administrative Director pursuant to Labor Code §5307. The WCAB pointed out that upon adoption by the AD of a utilization schedule pursuant to Labor Code §5307 the recommend guidelines shall be presumed correct on the extent of scope and extent of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance form the guidelines reasonably is required to cure or relive the injured worker form the effects of the industrial injury and these provision apply regardless of the date of injury. The WCAB indicated that the AD had adopted a medical treatment utilization schedule that incorporated the ACOEM guidelines. The WCAB indicated that the ACOEM guidelines were silent on the type of treatment at dispute in this case and since there was no negative recommendations a variance form the guidelines was not required. Only if the guidelines recommended against the treatment would the burden fall on the applicant to show that a variance was necessary.

Nevertheless, the WCAB added, that it remained the applicants burden of proof to prove be a preponderance of the evidence that the medical treatment for which reimbursement is sought was reasonably and necessarily required. The issue as to the modification of the vacation home is if defendants have already paid to modify the principle residence, do they have to also modify the vacation home and pay twice. The WCAB pointed out that there were an unlimited number of potential expenditures that would enhance the comfort, convenience and peace of mind of an injured worker, that a line had to drawn, however to limit the defendants liability to those that were reasonably required. Based on this consideration alone, the WCAB would not conclude that the modifications to applicant's vacation home were reasonably required treatment. Such a conclusion did not end the inquiry in this case, however. The WCAB noted that applicant' wife testified that there had been changes in how defendants had handled their requests for reimbursement. She said the first person they dealt with said the insurance company would modify three homes. When defendant denied that any such agreement

occurred, the WCAB indicated that defendant offered no testimony to that effect. The WCAB concluded in relevant part that the evidence was too vague and insufficient to determine whether defendants may have agreed or acquiesced to modifications of a third home, that the matter would be returned to the trial level to develop the record on this issue. If the parties are unable to resolve the issue between themselves the WCJ should further determine whether defendant made representations that applicant detrimentally relied. As to the in vitro fertilization the WCAB indicated that in the case of *Turi v. United Airlines* (29 Cal. Comp. Cases 126) an applicant as a result of a back injury was not able to father a child except by in vitro fertilization. The WCAB found that the defendant in that case was required to pay for the extraction of applicant's sperm, but not for the cost of the in vitro fertilization of the applicant's wife who was not the injured worker. The panel in the *Turi* case relied on the case of *Kennedy v. Argonaut Ins.* (25 Cal. Comp. Cases 243) an injured worker required back surgery with a 4 to 1 chance of leaving him incurably infertile. The treating physicians recommend that the applicant donate sperm so he could father children in the future and that the sperm donation related to the industrial injury and surgery for the industrial injury. The panel found the cost of the sperm donation was within the scope of Labor Code §4600, because the procedure was reasonably required to cure or relieve from the effects of the industrial injury. The WCAB concluded that in this case applicant as a result of back surgery was unable to father a child without in vitro fertilization. His condition is a consequence of his industrial injury and therefore the treatment to cure or relieve from the effects of the industrial injury is the responsibility of the defendant. Citing the two cases above concluded it was not the responsibility of the defendant to treat applicant's wife. Defendant is therefore only responsible for the sperm extraction. Upon return of the matter to the trial level, if the parties do not reach agreement, they should develop the record on the cost of the sperm extraction alone, apart from other aspects of the procedure, which do not involve treatment of the applicant. The WCJ should only issue an award for reimbursement of the cost that related to the applicants' treatment. The Writ was denied without prejudice to re-file should the board issue an order disposing of the issues raised in the petition on the merits.

Willis v. ACE American Insurance Co., (2011) 39 CWCR 63 (WCAB Panel) (Use of Labor Code §4062 necessary before WCAB challenge to UR denial.)

Applicant sustained an accepted cumulative injury to his knees. His primary treating physician recommended authorization for right knee arthroscopic chondroplasty and post-operative physical therapy. Defendant obtained a timely, physician's Utilization Review report denying authorization. Applicant, represented by counsel, requested an Expedited Hearing on the medical treatment issue. The issue was submitted on the treating physician's report and UR Physician's report; there had been no QME or AME report addressing the treatment issue. The WCJ found the treatment was necessary. Defendant filed a Petition for Removal.

The WCJ recommended that while there was no ground to support an extraordinary remedy, the appeal should be treated as a petition for reconsideration and granted. The Board dismissed the Petition for Removal and Granted Reconsideration on Board Motion. The Board ordered the matter remanded to utilize the procedure to challenge the UR decision outlined in Labor Code §4062. The procedure outlined in *Willette v. AU Electric*, (2004) 69 Cal. Comp. Cases 287 (WCAB En banc) of requiring use of the Labor Code §4062 procedure is no less applicable in represented injured cases than in unrepresented injure cases.

Accord: *Morales v. General Design Concepts*, (2011) 2 LexisNexis Workers Compensation e-Newsletter, issue 49 WCAB Panel). Following an MSC, defendant filed a Petition for Removal, requesting that the Appeals Board rescind the Order dated September 22, 2011, wherein the Workers' Compensation Administrative Law Judge (WCJ) ordered this case continued to trial, contending applicant failed to object to a utilization review (UR) decision holding that she did not require wrist surgery, and that prior to being able to adjudicate the issue before the WCAB she was required to obtain a comprehensive medical-legal evaluation as required by Labor Code sections 4610 and 4062. The Board granted removal and held:

"In this case, it is apparent that applicant objects to the UR determination. But instead of objecting and seeking further evaluation by Dr. Hasday pursuant to [section 4067](#), applicant filed a DOR, apparently relying on the medical reports of Dr. Haronian, the treating physician. As we have seen, this is not allowed by [sections 4610](#) and [4062](#). We also note that defendant has scheduled an examination by Dr. Hasday on January 11, 2012. Therefore, we grant removal and take this case off calendar pending evaluation by Dr. Hasday. After receipt of Dr. Hasday's report, either party may request further hearing if the pending issues are not resolved."

EVIDENCE / FORM, TIME, and MANNER OF FILING OF DOCUMENTARY EVIDENCE;
PRECEDENT EFFECT OF DECIONS:

HEARINGS & VENUE, DISCOVERY CUT OFF, WALKTHROUGH PROCEDURE:

Elias v. Saticoy Lemon Assoc., (2011) 39 C.W.C.R. 180 (WCAB Panel) (Further development of the record not appropriate where record could reasonably have been developed prior to MSC.)

The applicant filed an application for an injury to several body parts during employment as a laborer cumulatively through September 9, 2009. The matter came to hearing before a WCJ with issues of, among others, injury AOE-COE, post termination (Labor Code §3600(a)(10)), and statute of limitations defenses. The WCJ took into evidence documentary evidence, heard testimony and the matter was submitted for decision at the close of the hearing. The WCJ later vacated the submission and indicated that there was good cause to develop the record on the

issue of injury. The parties were ordered to obtain a formal job analysis and submit it to the treating physician, a panel QME, or an AME. Defendants filed a petition for reconsideration.

The WCAB panel found that reconsideration was not appropriate as no final order had issued, but found that removal was justified. The WCAB exercised its power to remove the case to themselves because they were persuaded the WCJ order to create additional evidence prejudiced the defendant. The WCAB indicated that Labor Code §5502 (d) (3) provides that discovery shall close on the date of the MSC. Evidence not disclosed or obtained thereafter not admissible in evidence unless the proponent of the evidence demonstrates it was not available or could not have been discovered by the exercise of due diligence before the MSC. This limitation cannot be circumvented by using the WCJ's power to develop the record the WCAB citing the case of *McKernan* (64 Cal. Comp. Cases 986). The WCAB concluded that the applicant had not demonstrated that there was any evidence he could not have discovered with the exercise of due diligence before the MSC occurred. By ordering the parties to obtain additional evidence the WCJ was, in effect, doing the applicant's attorney's job. The WCAB granted removal and rescinded the WCJ order vacating submission and returned the matter to the trail level and ordered the WCJ to decide the case on the current record.

French v. Warner Brothers, (2011) 39 C.W.C.R. 181 (WCAB Panel) (Venue, no good cause to change.)

Applicant signed a venue consent form agreeing to Marina Del Rey (MDR) as the office for the filing of his application which was filed at that office by his attorney. Applicant discharged his attorney and moved to North Carolina. Applicant obtained a new attorney who petitioned for change of venue to the Long Beach offices based on his convenience. Defendants objected based on the fact the injury occurred in Burbank, all the witnesses were in Burbank and the new attorney's principal place of business and moving it to Long Beach for his convenience was not good cause to change venue. The PWJ in MDR ordered venue changed to Long Beach. Defendants filed a petition for reconsideration.

The WCAB indicated that reconsideration was not a proper remedy as a change of venue order, because assignment of venue is not a final order. It dismissed the petition for reconsideration. However, the WCAB granted removal pursuant to Labor Code §5310 on its own motion and rescinded the change of venue order. The WCAB indicated that Labor Code §5501.5(a) sets for the location where an application can be filed: (1) the county where the injured employee resides (2) the county where the injury allegedly occurred (3) county of the attorney's principal place of business. If the county has more than one office the application can be filed in any office in that county. If applicant's written consent is filed with the application. If the defendants timely object the application shall be filed in the county where the applicant resides or the injury allegedly occurred. The person filing the application shall designate the venue and

the basis for the venue request. In this case the application was properly filed in MDR based on the attorney's principle place of business and defendants failed to timely object the choice of venue. The WCAB went on to state that Labor Code §5501.5(a) controls the location for filling an application however, Labor Code §5501.6 controls petitions for change of venue. That section requires that the petition (1) the petition specially set forth the reasons for the change of venue (2) if the change is requested for witness convenience, specifically set forth their names, addresses, and the substance of their testimony. The parties and the WCJ must follow the procedure outlined in WCAB rule 10411 and Labor Code §5501.6 for filling and ruling on petitions for change of venue and the parties are bound by the good cause requirement of Labor Code §5501.6. In this case the PWCJ confused Labor Code §§5501.5 and 5501.6 in making his decision on the petition for change of venue. Because MDR and Long Beach are in the same county, either would have been acceptable for filling of the original application. He chose MDR and defendants did not object so Labor Code §5501.5 no longer governed. Because applicant was filed for change of venue it was the applicant's burden to show good cause. The only reason given in applicant's petition was the fact that the applicant had moved to North Carolina and the applicant's attorney's principle place of business was in Long Beach. The WCAB failed to see how the applicant moving to North Carolina made Long Beach more convenient than MDR. Though both offices are in the same county applicant failed to show good cause for the change of venue pursuant to Labor Code §5501.6. The sole reason given in applicant's petition was the convenience of the attorney. The PWCJ did not make any finding of good cause nor did he explain his reasons for making the change. Whether location of the new attorney's office justified a change of venue required weighing that factor against all other pertinent factors. When the PWCJ asserted that defendant had not shown good cause for retaining the original venue the PWCJ misplaced the burden of proof. It was not defendants burden it was more convenient for the witnesses. Applicant had the burden to show good cause and convenience of the attorney failed to show good cause for the change of venue. The WCAB granted removal and the matter remained in MDR.

COMPROMISE & RELEASE:

LIENS, LIEN CLAIMANTS & LIEN CLAIMS, INTRPRETER LIENS:

California Pharmacy Management v. Workers' Compensation Appeals Board (Mendoza), (2011) 76 Cal. Comp. Cases 155 (Writ denied) (Reimbursement for repackaged pharmaceuticals, bases, and amount recoverable.)

Applicant sustained injury to his mid and low back, and both lower extremities cumulatively through January 2006, and on January 11, 2006. The applicant entered into a C and R which was approved. The C&R provided input that applicant did not sustain injury

AOE-COE to his psyche. The matter proceeded to trial on the lien of California Pharmacy Management in the amount of \$11,660.14. The pharmacy had an agreement with the applicant's treating physician to administer the pharmacy's drug- dispensing program utilizing repackaged drugs which the treating physician dispensed to the applicant. The WCJ awarded the pharmacy \$960.05. The pharmacy filed a petition for reconsideration. The WCJ recommend that reconsideration be denied.

The Workers' Compensation Appeals Board granted reconsideration and remanded the matter to the trial level for further proceedings. The Workers' Compensation Appeals Board explained that pursuant to the official fee schedule the maximum reasonable fee for a drug prior to adoption of the medical fee schedule by the Administrative Director (AD) may not exceed the fee specified in the 2003 fee schedule or 100% of the fees paid by Medi-Cal for drugs that require comparable resources. (Labor Code §5307.1(d), (e),) All of the pharmaceuticals dispensed to the applicant were dispensed between January 1, 2004 and February 27, 2007. On 1-2-04 the AD filed the regulation the maximum fee at 100% of Medi-Cal and providing that services and drugs not covered by Medi-Cal were governed by the 2003 Fee schedule. The Workers' Compensation Appeals Board pointed out that the medications at issue in this case were repackaged pharmaceuticals that were not included in the Medi-Cal payment system and are subject to the 2003 fee schedule.

According to the 2003 fee schedule reimbursement for pharmaceuticals is the lesser (1) the provider's (including medical provider) usual charge, or (2) the fees established by the formulas set forth in the Fee schedule for brand-names and generic drugs, which are based on average wholesale price and include a dispensing fee. When a generic pharmaceutical costs more than a brand-name pharmaceutical, the fair reasonable price will be the brand name equivalent, as calculated under the specific formula. The Workers' Compensation Appeals Board noted that this rule requires provider (here the physician) prove his usual charge, the amount her or she paid for the pharmaceuticals. If the claims administrator does not agree to reimburse the physician that amount plus the dispensing fee required by the rule, the claims administrator must prove that the formula set forth in the rule provides for a lesser reimbursement than the physician usual charge. In this case no evidence was introduced as to what the physician paid for the pharmaceuticals. The pharmacy must prove the physician actual charges. If the pharmaceutical products were samples provided at no charge there can be no reimbursement. In any event the charges cannot be higher than the brand name for the equivalent drug.

If defendant will not agree to reimburse those amounts, defendant must prove reimbursement under the formula provided by the rule is less than reimbursement of the actual charges. Where there is no evidence of the average wholesale price for a pharmaceutical, which appears to the case with this physician, the physician is entitled to reimbursement for his

actual charge if the medication was reasonably required. Anti-anxiety medical costs were allowable, whether or not there was psychiatric injury, if they were reasonably required to cure or relieve the effects of the injury. The Board directed that the issues be remanded without racing determination of lien claimant's claim for penalty and interest. Lien claimant filed a Petition for Writ of Review.

The writ was denied, with the Court noting it was an attempt to seek review of a non-final remand order not involving a threshold issue.

Bresler Ph. D., L. Ac. v. Workers' Compensation Appeals Board (Martinez), (2011) 76 Cal. Comp. Cases 251 (Writ denied) (Lien recovery limited to amounts provide in the Official Medical Fee Schedule absent proof of 'extraordinary circumstances.')

Applicant sustained injury to multiple body parts and systems on June 11, 1998. The case-in-chief settled by compromise and release. Dr. Silver provided treatment, and Dr. Bresler provided Acupuncture after the injury, and both were paid in part for their services, leaving \$31,477 of Dr. Bresler's \$43,205 charges in dispute. A lien trial was held. The WCJ found that Lien claimants were not entitled to payments exceeding those set forth in the Official Fee Schedule (OMFS). Lien Claimants petitioned for reconsideration.

The Workers' Compensation Appeals Board denied reconsideration finding that lien claimant did not prove that the fees allowed by the OMFS were unreasonable due to extraordinary circumstance related to the unusual nature of the services rendered. The Lien claimants did not prove that their claimed fees were reasonable and not in excess of their usual fees. The Workers' Compensation Appeals Board noted the fees schedule establishes for the services provided by a treating physician. Pursuant to rule 9792 (c) A medical provider may be paid a fee in excess of the reasonable maximum fee if the fee charged is reasonable and accompanied by itemization, and justified by an explanation of the extraordinary circumstances related to the unusual nature of the service rendered, and that the fee may not exceed the provider's usual fee. (*Kunz v. Patterson Floor Coverings, Inc.*, (2002) 67 Cal. Comp. Cases 1588). Pursuant to Labor Code §§ 3202.5 and 5705 the lien claimant had the burden of proving the amount charged is reasonable. (*Tapia v. Skill Master Staffing, Liberty Mutual*, (2008) 73 Cal. Comp. Cases 1338). The Workers' Compensation Appeals Board pointed out that the OMFS is reimbursement amount is established by rule 9792(c), as the *prima facie* reasonable amount, and that it is not defendants burden to disprove that there are extraordinary circumstances related to the unusual nature of the services rendered by each lien claimant. In this case the Workers' Compensation Appeals Board ruled neither lien claimant had met the burden of proof. The Workers' Compensation Appeals Board denied reconsideration and the writ was denied.

Guiron v. Santa Fe Extruders, State Compensation Insurance Fund, (2011) 76 Cal. Comp. Cases 228 (WCAB En banc) (Interpreters' Liens for services for treatment sessions; burden of proof; elements of proof. Value of panel decisions.)

Applicant injured his left elbow and psyche AOE-COE on April 14, 2006. The case in chief was settled by \$22,000.00 compromise and release approved on June 11, 2008. E&M's lien for \$13,988.00 in interpreter services was tried on June 21, 2010. E&M's services had been provided at medical examinations, chiropractic treatments and physical therapy sessions. Defendant contested liability for all of the services, contended that the interpreters were not certified, that treatments were with providers outside defendant's Medical Provider Network (MPN), that some services were billed for dates on which no underlying service was billed, and noted that some of the services were for therapy in excess of the limit authorized by Labor Code §4604.5(d).

Two issues, the reasonable value of the services rendered and E&M's entitlement to penalties and interest, were bifurcated and deferred, with jurisdiction reserved. No testimony was taken at trial, but various exhibits were admitted. SCIF introduced into evidence its claims adjuster's objection to lien claimant's billing, which stated that the billings were for self-procured medical treatment, that the treatment and the charges were not reasonable or necessary, that the interpreting services were for an examination that SCIF had objected to, and that the treating doctors are not part of SCIF's medical provider network. SCIF also introduced its Individual Payment Reports, which included "Reviewer's Comments" explaining why particular billings were not paid — for example, that there was no record of medical treatment occurring on the date billed by the interpreter, and that there was insufficient documentation of the medical necessity for an interpreter at the treatment visit.

The workers' compensation administrative law judge (WCJ) had found, in his October 1, 2010 Findings, Award and Order Re: Lien of E&M Interpreting, that the interpreting services rendered by E&M at the Primary Treating Physician's initial and final examinations on June 20, 2006, and February 9, 2007, were reasonably required to cure or relieve the effects of applicant's industrial injury, and that the remainder of E&M's unpaid services were not reasonable or necessary. The WCJ disallowed most of the lien, indicating that use of the Spanish language in East Los Angeles was so pervasive that interpreter services during medical treatment appointments would never be reasonably required. The WCJ did not reach or rule on defendant's other bases for objection. Lien claimant sought reconsideration.

The WCJ indicated in his Report and Recommendation on Reconsideration that:

“If an interpreter is necessary to enable an injured worker to communicate with his or her medical provider, understand treatment recommendations and make decisions

regarding them, and to participate in treatment, then an interpreter should be provided as part of the cost of the injured worker's medical care." (Report, p. 3.)

He added, however,

"In the present case, there is no evidence that Spanish interpreting services were necessary in order for Mr. Guitron to obtain physical therapy and chiropractic treatment. Lien claimant's Exhibit 2 reveals that the interpreting services were performed at offices in East Los Angeles. In that part of the city, Spanish is the primary language, and it is reasonable to believe that medical offices (physicians, chiropractors and physical therapists) serving that community are staffed primarily (if not entirely) by people who speak Spanish. Because the lien claimant has the burden of proof, it is lien claimant's burden to prove that the offices at which interpreting services were performed did *not* have a Spanish-speaking staff member available to interpret, as well as whether interpretation was required. Even if those offices did not have the ability to speak directly to the patient in his language, it would not necessarily render Spanish interpreting services reasonable and necessary, since East Los Angeles (and all of Southeast Los Angeles County, where applicant lived and worked) has numerous physical therapy and chiropractic offices which are Spanish-speaking." (*Id.* at pp. 3-4.)

The WCJ explained that the question of whether interpreting services for *all* medical visits are reimbursable, when the injured worker does not speak English, is an unsettled issue on which there is no binding case authority, and is an issue of great importance in Southern California.

The Appeals Board granted reconsideration, initially to allow time to study the record and applicable law. On reconsideration, E&M contends the WCJ erred in denying most of its lien for interpreting services provided during applicant's medical treatment. The Appeals Board acknowledged that the issues in dispute in this case are of broad concern to the workers' compensation community, and that the issue has not, until now, been addressed in a precedential decision. Because of those important legal issues regarding the right to payment for interpreting services during medical treatment, and to secure uniformity of decision in the future, the Chairman of the Appeals Board, upon a majority vote of its members, assigned this case to the Appeals Board as a whole for an en banc decision.

The Workers' Compensation Appeals Board held that: (1) pursuant to the employer's obligation under Labor Code §4600 to provide medical treatment reasonably required to cure or relieve the injured worker from the effects of his or her injury, the employer is required to provide reasonably required interpreter services during medical treatment appointments for an injured worker who is unable to speak, understand, or communicate in English;

(2) to recover its charges for interpreter services, the interpreter lien claimant has the burden of proving, among other things, that the services it provided were **reasonably**

required, that the services were **actually provided**, that the **interpreter was qualified** to provide the services, and that the **fees charged were reasonable**.

In reaching the holding on an interpreter lien claimant's burden of proof, the Workers' Compensation Appeals Board emphasized that the discussion is not all-inclusive and that, in any given case, the **lien claimant also might be required to carry its burden with respect to issues we have not addressed**, including but not limited to the issue of injury arising out of and in the course of employment, if contested. The methods the Workers' Compensation Appeals Board discussed were neither exclusive nor mandatory.

One issue was whether interpreters for medical treatment must be "certified" or "qualified," and whether there is a material difference between the two. E&M argued in its brief that applicant was entitled to the services of a qualified interpreter during medical treatment appointments, pursuant to §4600 and Administrative Director (AD) Rule 9795.3 (Cal. Code Regs., tit. 8, § 9795.3). SCIF argued that interpreter fees are allowable only in connection with medical-legal expenses or evaluations, and not in connection with physical therapy and chiropractor visits. SCIF argued that, even if such services are found to be reasonable and necessary for medical treatment, the interpreter should be required to provide the information required by §4628(b) for physicians preparing medical-legal reports. SCIF complained that, in this case, "The reports for physical therapy and chiropractic treatment do not indicate that an interpreter was used, let alone disclose the name or qualifications of the interpreter. If there is no indication on the report that an interpreter was used, how can State Fund verify that interpreting services were actually provided." (Defendant's Trial Brief on Lien of E&M Interpreting, 4:6-10.)

The Labor Code and the AD Rules require a defendant to provide interpretation services in several specified circumstances. Labor Code §5710(b)(5) provides that, when a defendant requests the deposition of an injured worker or person claiming dependent benefits, the deponent is entitled to reasonable allowance for interpreter's fees for the deponent, if interpretation services are needed and provided by a language interpreter certified or deemed certified pursuant to Article 8 (commencing with §11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or §68566 of, the Government Code. Labor Code §4600(f) provides for a reasonable fee for "qualified interpreters" at a required medical "examination." 'Qualified interpreter' means a language interpreter certified, or deemed certified, pursuant to Article 8 (commencing with §11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or §68566 of the Government Code. Section 4620(a) includes interpreter's fees within the definition of medical-legal expenses, if "the medical report is capable of proving or disproving a disputed medical fact." (Labor Code §4620(c).) §4621(a) includes the cost of interpreter services among medical-legal expenses "reasonably, actually, and necessarily incurred," which shall be reimbursed. Section 5811(b) addresses interpreter fees as a cost of workers'

compensation litigation where required to allow testimony of a witness at a hearing or deposition, and again, the term “qualified interpreter” is defined as “a language interpreter who is certified, or deemed certified, pursuant to Article 8 (commencing with §11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or §68566 of, the Government Code.” Regulations also authorize qualified interpreter costs for applicants in need of such services at conference hearings or arbitration

AD Rule 9795.4 (Cal. Code Regs., tit. 8, § 9795.4) governs the time for payment of, and objections to, interpreter expenses:

“(a) All expenses for interpreter services shall be paid within 60 days after receipt by the claims administrator of the bill for services unless the claims administrator, within this period, contests its liability for such payment, or the reasonableness or the necessity of incurring such expenses. A claims administrator who contests all or any part of a bill for interpreter services shall pay the uncontested amount and notify the interpreter of the objection within 60 days after receipt of the bill. Any notice of objection shall include all of the following:

“(1) An explanation of the basis of the objection.

“(2) If additional information is needed as a prerequisite to payment of a contested bill or portions thereof, a clear description of the information required.

“(3) The name, address and telephone number of the person or office to contact for additional information concerning the objection.

“(4) A statement that the interpreter may adjudicate the issue of the contested charge before the Workers' Compensation Appeals Board.

“(b) Any bill for interpreter's services which constitutes a medical-legal expense as defined in subdivision (g) of Section 9793 and which is neither paid nor contested within the time limits set forth herein shall be subject to the penalties and interest set forth in Labor Code §4622..

“(c) This article shall be effective for services provided on and after the effective date of this article which pertain to injuries occurring on or after January 1, 1994. Amendments to this article which became effective in 1996 shall apply to interpreting services provided on or after April 1, 1997.”

The Appeals Board found and reviewed a wealth of authority on interpreter services, but none directly applicable to medical treatment. Although no statutory or regulatory provision specifically provides for interpretation services during medical treatment appointments, the Workers' Compensation Appeals Board held that, pursuant to the employer's obligation under §4600 to provide medical treatment reasonably required to cure or relieve the injured worker from the effects of his or her injury, the employer is required to provide reasonably required

interpreter services during medical treatment appointments for an injured worker who is unable to speak, understand, or communicate in English.

The Appeals Board reviewed statute and regulatory requirement to provide reimbursement for payment of travel expense to treatment, medical evaluation, hearings, etc. Like transportation, effective communication between an injured employee and a medical provider is an essential adjunct to treatment. This common sense principle has been recognized in a number of Appeals Board panel decisions. (E.g., *Garcia v. State Comp. Ins. Fund* (2001) 29 C. W. C. R. 310; *Paguada v. Amberwood Products* (2008) 2008 Cal. Wrk. Comp. P.D. LEXIS 92; *Saldana v. 3M Espe*, (2008) 2008 Cal. Wrk. Comp. P.D. LEXIS 417 (*Saldana*); *Gil v. Shea-Kenny Joint Venture* (2007) 2007 Cal. Wrk. Comp. P.D. LEXIS 219; *Perez v. A's Match Dyeing* (2007) 2007 Cal. Wrk. Comp. P.D. LEXIS 112.) To paraphrase our admonition in *Jones, supra*, 62 Cal. Comp. Cases at pp. 1259-1260, quoted above with regard to transportation expenses, were the cost of an interpreter not included in medical treatment benefits, the injured worker might be deprived of necessary benefits, defeating the fundamental purpose of extending benefits for the protection of persons injured in the course of their employment.

The Appeals Board found no *legal* basis for drawing a distinction between types of treatment, or that compensation for interpreter services at some treatment appointments might be justified, but not at others, such as chiropractic manipulations, physical therapy, and, particularly, work conditioning. If the services provided constituted “medical treatment,” if the treatment was reasonably required to cure or relieve from the effects of an industrial injury, and if qualified interpreter services were required and provided during the treatment, then the interpreter services may be compensable under §4600, regardless of the nature of the medical treatment involved.

The WCJ’s decision in the present case does not reflect any disagreement with the principles discussed above. Rather, he denied most of E&M’s lien because he found, as a factual matter, that, except for Dr. Boyarsky’s initial and final evaluations, the billed interpreter services were not reasonable or necessary. In other words, the WCJ determined that E&M had not met its burden of proving its right to payment of its lien.

To recover its charges for interpreter services, the interpreter lien claimant has the burden of proving, among other things, that the services it provided were reasonably required, that the services were actually provided, that the interpreter was qualified to provide the services, and that the fees charged were reasonable.

“The burden of proof rests upon the party or lien claimant holding the affirmative of the issue.” (Labor Code, §5705.) Section 3202.5 provides that, “All parties and lien claimants

shall meet the evidentiary burden of proof on all issues by a preponderance of the evidence....”

Although we agree with E&M that, as a general principle, interpreter fees may be allowed in conjunction with, and as a component of, medical treatment, this does not mean that interpreter liens are automatically payable. As explained above, interpreter services are authorized under §4600’s general requirement that employers provide medical treatment reasonably required to cure or relieve the injured worker from the effects of the industrial injury. Therefore, like other medical lien claimants, interpreter lien claimants have the burden of proving their right to payment. (Labor Code, §§3202.5, and 5705; *Zenith Ins. Co. v. Workers’ Comp. Appeals Bd. (Capi)*, (2006) 138 Cal.App.4th 373, 376-377; 71 Cal. Comp. Cases 374 (*Capi*); *Kunz v. Patterson Floor Coverings, Inc.*, (2002) 67 Cal. Comp. Cases 1588 (WCAB en banc) (*Kunz*); *Tapia v. Skill Master Staffing*, (2008) 73 Cal. Comp. Cases 1338 (Appeals Board en banc) (*Tapia*)). For guidance to the workers’ compensation community, we will now consider the various elements of the interpreter lien claimant’s burden of proof, and what evidence may satisfy that burden.

One element of an interpreter lien claimant’s burden is to show that the injured worker required an interpreter. If an injured worker used an interpreter, but did not need one, the defendant should not be obligated to pay for the interpreter services. “An employee who cannot communicate in English” during a deposition, an appeals board hearing, and those settings the AD determines are reasonably necessary to ascertain the validity or extent of injury requires an interpreter. In the various settings for which the right to an interpreter is expressly authorized by statute or regulation, the injured worker must need assistance because he or she does not adequately speak or understand or communicate in English.

An injured worker’s need for an interpreter could be demonstrated in many ways. If, for example, an interpreter was used during the deposition of the worker (see Labor Code, §§5710(b)(5), 5811(b)(1)) or at an agreed or qualified medical evaluation (see Labor Code, §§4600(f), 4620(a) & (c), 4621(a); Cal. Code Regs., tit. 8, § 9795.3(a)), although not conclusive, it might be reasonable to infer that the worker needed interpreting services during medical treatment. A physician’s statement that an interpreter was required, an interpreter’s testimony or sworn statement that he or she confirmed with the physician that interpreting services were needed, or the worker’s testimony through an interpreter that he or she needed an interpreter to communicate with a medical provider could all constitute evidence of the need for an interpreter. If the defendant authorized interpreter services for some medical treatment appointments, it should not be necessary for the interpreter lien claimant to prove that interpreter services were required for each individual appointment, unless defendant raises a legitimate objection to a particular date of service. Ultimately, if there is a dispute, it will be up to the trier-of-fact to determine whether the interpreter lien claimant has demonstrated that

the interpreter services were reasonably required. The parties may present any evidence that is probative on the issue.

The interpreter lien claimant must also establish that an interpreter was actually present at the medical appointments in question, i.e., that the interpreter actually rendered the services being billed. As part of this burden, if the issue is disputed, the interpreter lien claimant must also establish that the medical treatment occurred on the interpreter's billed dates of service. Although there is no current requirement for a treating physician to indicate the presence of an interpreter (see 8 Cal. Code Regs. §§ 9785.2, 9785.3, 9785.4, 10606), it is certainly appropriate and helpful for a physician to do so. SCIF's suggestion that interpreter lien claimants prepare disclosures similar to those required for physicians by §4628(b) provides another option for a lien claimant to demonstrate satisfaction of this element.

The burden of proving that the services were required, and that they were provided, may also be satisfied by the interpreter using a form, signed by the medical provider in conjunction with the visit, containing a statement to the effect that a named interpreter was present, that the medical practitioner is not proficient in the injured employee's language, and that the practitioner's office does not provide interpreters, and the office's policy is that patients who are not proficient in English should be accompanied by an interpreter. (See *Saldana, supra*, 2008 Cal. Wrk. Comp. P.D. LEXIS 417.)

The methods discussed above are neither mandatory nor exclusive. There may well be other ways to satisfy lien claimant's burden. To avoid these issues, however, the preferred practice is to obtain pre-authorization. (*Saldana, supra*, 2008 Cal. Wrk. Comp. P.D. LEXIS 417.) When a treating physician requests authorization for treatment by another practitioner, such as a physical therapist, chiropractor, or acupuncturist, the treating physician could include in the request a statement that the injured worker requires the services of an interpreter. The defendant could then efficiently and unambiguously authorize use of an interpreter in conjunction with the requested treatment. However, a treating physician's failure to expressly request an interpreter, by itself, is not a basis to conclude that an interpreter is not reasonably required.

An interpreter lien claimant must also prove that the interpreter was qualified to provide the billed services. A "qualified interpreter" means a "certified" or "provisionally certified" interpreter pursuant to AD Rule 9795.1(f) (8 Cal. Code Regs. § 9795.1(f)), or, for purposes of §4600, a "qualified interpreter" means an interpreter certified or deemed certified pursuant to the Government Code. When the setting is not "an appeals board hearing, arbitration, or formal rehabilitation conference," and when a certified interpreter cannot be present, a "provisionally certified" interpreter is one deemed qualified to perform interpreting services by agreement of the parties. (8 Cal. Code Regs. §9795.1(e).) Thus, for a medical examination, a provisionally certified interpreter is one deemed qualified by agreement of the parties, when a

certified interpreter is unavailable. While a treatment appointment is not strictly governed by these provisions, we see no logical reason why the qualifications for an interpreter at a treatment appointment should be any different or less rigorous than the qualifications for an interpreter at a medical examination.

Government Code §11435.55 suggests another option. It provides that, when a certified interpreter cannot be present at a medical examination, “the physician provisionally may use another interpreter if that fact is noted in the record of the medical evaluation.” While agreement between the parties is preferred, a non-certified interpreter lien claimant seeking payment for services performed during medical treatment could show that it was selected “provisionally,” under Government Code §11435.55, if use of the non-certified interpreter is recorded by the physician.

If a lien claimant succeeds in proving that its interpreter was qualified, that it provided the billed services, and that the services were reasonably required, the lien claimant must still prove the reasonableness of its charges. AD Rule 9795.3(b)(2) (8 Cal. Code Regs. §9795.3(b)(2)) provides the following fee schedule for interpretation at all events listed in subdivision (a), other than a hearing, arbitration, deposition, or rehabilitation conference:

“interpreter fees shall be billed and paid at the rate of \$11.25 per quarter hour or portion thereof, with a minimum payment of two hours, or the market rate, whichever is greater. The interpreter shall establish the market rate for the interpreter’s services by submitting documentation to the claims administrator, including a list of recent similar services performed and the amounts paid for those services.”

“Market rate” is defined as “that amount an interpreter has actually been paid for recent interpreter services provided in connection with the preparation and resolution of an employee's claim.” (8 Cal. Code Regs. §9795.1(h).)

The fee schedule does not apply directly to interpreter services for medical treatment, since treatment is not one of the enumerated settings. Still, we may look to the fee schedule for guidance as to what a reasonable fee may be. (Cf. *Roberson v. Atlantic Mut. Ins. Co.* (2006) 34 C. W. C. R. 190 (Appeals Board panel decision) We are not prepared to conclude that the two-hour minimum applies to all medical treatment appointments, some of which might take only 10 to 15 minutes. (See *Di Giuseppe v. Workers’ Comp. Appeals Board (Menjivar)* (2002) 67 Cal. Comp. Cases 1003 (writ denied) [\$45.00 per visit was considered adequate payment for interpreting services at medical treatment appointments that were not shown to last longer than one hour].) On the other hand, we understand that, without some minimum rate of reimbursement, there might not be a sufficient incentive for interpreters to provide services during medical treatment, and injured workers would, therefore, be deprived of this necessary adjunct to medical treatment.

As with selection of a qualified interpreter, the preferred practice with regard to fees is for the parties to agree in advance. This practice is specifically endorsed by AD Rule 9795.3(d), which states, “Nothing in this section shall preclude payment to an interpreter or agency for interpreting services based on an agreement made in advance of services between the interpreter or agency and the claims administrator, regardless of whether or not such payment is less than, or exceeds, the fees set forth in this section.” (8 Cal. Code Regs. §9795.3(d).)

If the parties have not agreed in advance, and cannot agree after the fact, it will be the interpreter lien claimant’s responsibility to offer any probative evidence as to the reasonableness of its charges; and it will be the trier of fact’s responsibility to determine whether the lien claimant has succeeded in proving its fee was reasonable. If the lien claimant has not proved its fee was reasonable, but has otherwise proved its right to recover, the trier of fact must determine and award a reasonable fee.

SCIF argued that E&M did not prove that its services were necessary, that its interpreters were qualified, that interpreter services were provided on all the dates billed, or even that medical treatment took place on all of those dates. Because these elements were part of E&M’s burden of proof, it was E&M’s responsibility to offer evidence on those issues.

SCIF further objected to payment of most of the billed services on the following grounds: the medical treatment was unauthorized, the medical provider was not part of defendant’s medical provider network, and the treatment exceeded the 24-visit limitation on chiropractic care and physical therapy established in §4604.5(d)(1). Once these objections were raised by defendant, it fell to lien claimant to rebut them. If the injured worker was not entitled to the underlying medical treatment, the interpreter’s lien must be disallowed for the services in question. Of course, if a defendant has no reasonable basis for disputing an interpreter’s lien, or if a defendant frivolously asserts defenses, while possessing proof that its allegations are false, the defendant will expose itself to potential penalties under §5814 and sanctions under §5813.

The standard adopted by the WCJ was overly limited in implying that a medical provider would be required to use a staff member with other duties to interpret for an injured unable to speak English, that an interpreter must prove that there were no *other* medical providers in the area who could provide the treatment, using the injured worker’s language, or in determining without probative evidence that a given language was so pervasive in a given neighborhood that translation services for treatment in that neighborhood would not be necessary .

The WCJ did not reach any of these issues because he found preliminarily that E&M had failed to prove that most of its services were reasonable and necessary. Because, in some respects, the WCJ misapplied E&M’s burden of proving that its services were reasonably required during medical treatment, and because he improperly distinguished Spanish from other languages, we will amend his decision to defer decision on those parts of the lien

disallowed by the WCJ, and return the matter to the trial level for further proceedings and decision, consistent with this opinion. Because this opinion represents the first detailed and binding explanation of the interpreter lien claimant's burden of proof with regard to medical treatment, we think it appropriate in this case to reopen the record and allow the parties to conduct further discovery, if necessary, and to introduce additional evidence on the issues addressed in this opinion. If, upon return of this matter, the WCJ reaches a different conclusion as to whether E&M's services were reasonably required, it will then be necessary for him to consider defendant's other defenses.

Only the disallowed parts of the lien require further consideration by the WCJ in light of this opinion. There has been no challenge to the WCJ's allowance of the lien for the June 20, 2006 and February 9, 2007 dates of service, or to his admission into evidence of lien claimant's Exhibits 12 and 13. Therefore, we will affirm the Findings and Award & Order, except that we will amend it to defer decision on the remainder of the lien, i.e., those dates of service found by the WCJ to be not reasonable and necessary.

At footnote 7, at 76 Cal. Comp. Cases 228, page 242 notes that "while it is true that Appeals Board panel decisions are not binding precedent and have no *stare decisis* effect (*Gee v. Workers' Compensation Appeals Board*, (2002) 96 Cal. App. 4th 1418, at p. 1425, fn. 6; 67 Cal. Comp. Cases 236), we consider them to the extent we find their reasoning persuasive. Unlike unpublished appellate court opinions, which, pursuant to California Rules of Court, rule 8.1115(a), may not be cited or relied on, except as specified by rule 8.1115(b), Appeals Board panel decisions are citable, even though they have no precedential value. (See *Griffith v. Workers' Comp. Appeals Board*, (1989) 209 Cal. App. 3d 1260, 1264, fn. 2; 54 Cal. Comp. Cases 145.)"

Montalvo v. Adir Restaurant, (2011) ADJ3545068 (Board Panel) (Dismissal of lien for failure to appear at hearing.)

Applicant sustained injury on October 30, 2007. The case in chief was closed by Compromise and Release approved at walkthrough on November 17, 2010. Lien proceedings were scheduled and four liens allowed in February 2011. A further hearing was set for June 20, 2011; but did not proceed due to failure of parties to appear. Thereafter four additional liens were allowed, and Notices of Intent to Dismiss Lien were issued on July 5, 2011, as to six additional lien claimants including Dr. Kevin Arminian. Orders dismissing eight liens issued August 8, 2011. On August 15, 2011, Dr. Kevin Arminian, M. D., filed a Petition for Reconsideration, contending that the WCJ's decision dismissing the lien for failure to appear was improper due to the defendant's alleged failure to provide adequate notice that applicant's claim had been resolved, and that lien claimant's personnel appearance was required. The

WCJ noted in his report and recommendation on reconsideration that the WCJ issued a notice of intention to dismiss for failure to appear and the objection of lien claimant was insufficient.

The WCAB noted that in this case the file contained no proof of service of the Compromise and Release or Order Approving Compromise and Release on the lien claimant as required by WCAB Rule 10886. The WCAB noted that defendant had not filed and answer to lien claimant's Petition for Reconsideration, and failed to file proof of service pursuant to Rule 10886. The WCAB granted reconsideration and rescinded the order of dismissal of the lien. The matter was returned to the trial level for a conference whereupon defendant shall be ordered to provide proof of service of the compromise and release agreement pursuant to rule 10886. However, if defendant is unable to provide proof of service in compliance with rule 10886, showing service upon lien claimant prior to the order of dismissal of the lien claim, the WCJ is ordered to issue a notice of intention to sanction defendant in the amount of \$500, unless good cause can be shown why defendant did not provide a proof of service of the Compromise and Release on lien claimant. The WCAB went on to state if proof of service of the Compromise and Release pursuant to rule 10886 had been accomplished by defendant prior to the Order of Dismissal and is provided to the WCJ at the lien conference, the WCJ is ordered to issue a notice of intention to sanction the lien claimant \$500 for failure to attend the hearing in June 1011 and the dismissal of the lien shall be reinstated.

FINDINGS AND AWARD AND ORDERS:

Colleran v. Workers' Compensation Appeals Board (City of Los Angeles), (2010) 75 Cal. Comp. Cases 1322 (Court of Appeal Unpublished) (Finality of Award or Order – D&O of Rehab Unit in 2008 not appealed is final even if time for timely appeal ran into 2009.)

Applicant was injured on April 28, 1999, and applied for vocational rehabilitation benefits on December 2, 2008. She obtained a Determination and Order of the Rehabilitation Unit on December 29, 2008 ordering provision of vocational rehabilitation benefits. On January 1, 2009 Labor Code §139.5 (providing vocational rehabilitation as a mandatory benefit for injuries between 1975 and was repealed.) In *Weiner v. Ralphs Company*, (2009) 74 Cal. Comp. Cases the appeals board held that the right to any vocational rehabilitation benefit terminated on December 31, 2008, unless supported by an order or award final before January 1, 2009. Defendant did not file an appeal from the December 29, 2008 Determination and Order. The City disputed liability for the benefits, contending that the Determination and Order was not final before January 1, 2009, because it was, by its terms, subject to appeal within twenty days. At a hearing on June 28, 2009, there was an offer of proof that defendant's adjuster did not receive a copy of the Determination and Order until April 10, 2009, and was stipulated that no appeal was taken from the order within twenty days of its actual receipt. The

WCJ found that the order had become final as of the date it issued when it was not appealed. Defendant sought reconsideration.

The Workers' Compensation Appeals Board granted reconsideration and reversed. , Relying on the en banc decisions in *Weiner v. Ralph's Company* (2009) 74 Cal. Comp. Cases 736 and *Weiner v. Ralphs Company* (2009) 74 Cal. Comp. Cases 958, the Appeals Board found that the 12/29/08 determination of the RU was not a "final enforceable Order" because Colleran's right to VR benefits and services "did not become vested" before 1/1/09, and, accordingly, that Colleran was not entitled to VR benefits. Applicant sought review.

The Court of Appeal granted review. It noted that in in *Los Angeles County Fire Dept. v. Workers' Compensation Appeals Board (Norton)*, (2010) 184 Cal.App.4th 1287; 75 Cal. Comp. Cases 421 that part of a 2008 Rehabilitation Unit D&O imposing VRMA at the delay rate was appealed, but the entitlement to VRMA itself was not appealed. It was held in *Norton* that the worker's right to vocational rehabilitation maintenance allowance ended with the repeal of Labor Code §139.5 **only to the extent of the award that had not become final.** (I.e. applicant was entitled to VRMA at \$246 per week, not the disputed "delay rate.")

The Court rejected defendant's argument that the repeal of Labor Code §4645(d) deprived it of a means of appeal, noting 8 Cal. Code of Regs. §10293 and Labor Code §5502(b)(3) providing an expedited hearing as a basis for resolving vocational rehabilitation disputes. Based on decisions on date of finality of an unappealed decision or order in *Lomeli v. Department of Corrections*, (2003) 108 Cal. App. 4th 788, *Pressler v. Donald L. Bren Co.*, (1982) 32 Cal. 3d 831, and 3 WCAB panel decisions the majority (2-1) held that the determination of the RU became final when no appeal was filed.

The Supreme Court of California denied the employer's petition for rehearing in the case of *Colleran v. Workers' Compensation Appeals Board (City of Los Angeles)*.

RECONSIDERATION & REMOVAL

***Hamilton v. Workers' Compensation Appeals Board (Fremont Compensation Insurance in liquidation, by California Insurance Guarantee Association)*, (2011) (Case Number D060674) (Writ Denied) (Extraordinary nature / irreconcilable harm required to support removal; denial of expedited hearing on complex issues is not.)**

Applicant sustained industrial injury in 1984 while employed by Toyota of Poway. The Workers' Compensation Administrative Law Judge who heard testimony and issued various findings and orders and, and on September 20, 2001, issued an Order Approving Compromise

and Release. On July 22, 2010, Petitioner filed a Declaration of Readiness to Proceed and a Petition to Reopen. He sought to void the compromise and release agreement, annul the 1988 award, vacate prior stipulations, and obtain temporary disability benefits, penalties, attorney fees and an award of total permanent disability benefits. The case was set for hearing before another WCJ. Respondent California Insurance Guarantee Association requested the case be transferred to back to the WCJ who had heard the case because that WCJ had previously taken testimony and issued orders in the case. The case was reassigned to that WCJ and a hearing set for March 14, 2011. Hamilton petitioned for reconsideration. The WLJ recommended denial.

The WCAB dismissed the petition for reconsideration in that an order for reassignment of a case is not a final order. Considering it a petition for removal, it denied the petition. The March 14, 2011 hearing date was cancelled and the matter was set for hearing for November 29, 2011, before the second WCJ because the first WCJ had retired. On June 30, 2011, Petitioner filed a Declaration of Readiness to Proceed to Expedited Hearing, seeking rescission of the Order Approving Compromise and Release, enforcement of a 1986 award of temporary disability benefits, reopening of his case and commutation of future payments, and claiming entitlement to temporary disability benefits. The request for expedited hearing was denied.

On August 1, 2011, applicant filed a Petition for Removal and for an order to stay the November 29, 2011, hearing. The WCJ recommended the petition be denied.

The WCAB denied the petition. Statutory bases for review of a final decision of the WCAB are limited to whether the WCAB acted without or in excess of its powers and whether the order, decision or award was not supported by substantial evidence, whether new evidence unavailable at hearing warrants reversal, whether the findings of fact fail to support the decision, award or order, or whether the award was procured by fraud. The court stated that they could not say the WCAB acted without or in excess of its powers or that the decision is not supported by substantial evidence or procured by fraud. The record shows Petitioner's request for an expedited hearing was properly denied. His declaration of readiness to proceed to expedited hearing shows he raises complex issues that could not be heard adequately at an expedited hearing, and the case had already been set for a full-day hearing on November 29, 2011. Petitioner claims he is seeking temporary disability indemnity, which is an issue that may be heard at an expedited proceeding. (Labor Code §5502(b).) However, he is also seeking to reopen his case and void the compromise and release agreement that was approved in 2001. The WCJ could have reasonably concluded that the issues are too complex for an expedited hearing and require adjudication at a regular hearing. His request for a stay of the November 29, 2011, hearing is without merit and would cause further delay. As to Petitioner's petition for removal, the WCAB has discretion to remove itself or transfer the proceedings on any claim to a WCJ. (Labor Code §5310.) However, this is an extraordinary remedy available only when the Petitioner has established substantial prejudice or irreparable injury if removal is

not granted. (Cal. Code Regs., tit. 8, §10843.) Petitioner had not made the required showing for removal; the petition was denied. Applicant's petition for writ of review was denied.

RES JUDICATA & COLLATERAL ESTOPPEL

REOPENING:

State Compensation Insurance Fund v. Workers' Compensation Appeals Board (Hancock), (2010) 75 Cal. Comp. Cases 1336; 38 CWCR 296 (Court of Appeal, unpublished) (Reopening – new body parts -- effect of general release in stipulations.)

In 2002 Hancock filed a cumulative trauma claim of injury to his low back, both knees, and both hands while employed as an ironworker by D & M Hancock, his family's business. Based on the medical reports of agreed medical examiner (AME) Dr. Michael Sommer, the parties settled Hancock's claim in 2005 by way of stipulations with a request for award. As pertinent here, the parties stipulated Hancock sustained industrial cumulative injury through July 31, 2001, to his low back, left and right knees, and bilateral carpal tunnel. The parties stipulated for 49 percent permanent disability and the need for further medical treatment of such injuries. Paragraph 8 of the parties' stipulated award contained, among other things, the following language: "This agreement resolves all issues of liability for any injury specific or cumulative for plaintiff's entire period of employment with this employer." The WCJ made an award to Hancock consistent with and expressly incorporating the stipulations of the parties.

In 2005, Hancock filed a petition to reopen for new and further disability. Hancock alleged his injury had worsened and that he had sustained new and further disability as a result of said injury. He alleged his disability had increased in his subjective complaints, objective findings, and increased work restrictions. As a result, he had a need for further temporary disability, permanent disability, medical treatment, and vocational rehabilitation. Finally, he also alleged injury to previously unmentioned body parts: his bilateral shoulders. Hancock was reevaluated by AME Dr. Sommer in November 2006. Dr. Sommer noted in his 2006 report history that Hancock told him "of continuing troubles with his knees and low back, but also with his shoulder, principally left-sided, since [they] talked last two and a half years ago. While when we first spoke, [Hancock] clearly placed symbols on the body image to show pain in his left shoulder, that anatomic part is never cited in my 13 page report. There is one citation to his right shoulder only[.]" Further discussing Hancock's left shoulder, Dr. Sommer said Hancock "recalls sometime in the early 1990s that he was working as a steel erector and grabbed the flange of something with his left hand and had a real jerking injury to the left shoulder, was briefly off work and just sort of sucked it up and lived with it since then. He says that it has been a continuing problem and in the last couple of years, has been worse[.]"

Dr. Michael Sommer examined Hancock's shoulders and reviewed a CT scan and X-rays of his left shoulder. Sommer diagnosed Hancock with glenohumeral arthritis in his left shoulder. Sommer found "solid reason for [Hancock] to be symptomatic in the left shoulder, given the extent of osteoarthritis in the glenohumeral joint." Dr. Sommer believed the shoulder condition was work related, that it should properly be included with the cumulative July 31, 2001 injury, and that Hancock would probably need a shoulder arthroplasty eventually, but in the meantime, it was appropriate to view Hancock as permanent and stationary with respect to his left shoulder.

Hancock's Petition to Reopen was submitted to the WCJ for decision based on the reports of Dr. Sommer, Dr. Norris and Hancock's deposition. The WCJ initially found that Hancock did not sustain an industrial injury to either shoulder, that Hancock had not shown good cause to reopen his award of low back or carpal tunnel disability, and that the record was inadequate to determine Hancock's claimed increase in disability to his knees. The denial of Hancock's claim of industrial injury to his bilateral shoulders was based on the WCJ's legal conclusion that the claim was waived by the parties' stipulation in the prior award. The WCJ stated: "Simply to illustrate the situation a bit more thoroughly, if medical evidence existed that showed that [Hancock's] shoulder(s) problems had arisen by sequelae, from the original cumulative injury, they could upon that basis now be found to be compensable. This is not, of course, the case here, the AME is essentially saying that the shoulders were industrially injured via the same cumulative trauma mechanism as the back, both knees and both carpal tunnels. Applicant filed a Petition for Reconsideration, and the WCJ vacated his decision and order.

In a new Supplemental Findings and Order, the WCJ found the parties had stipulated that Hancock sustained injury to his low back, both knees, and bilateral carpal tunnels as the result of cumulative trauma through July 31, 2001. The WCJ found Hancock had also sustained injury to his left shoulder and he may have sustained injury to his right shoulder. With respect to Hancock's shoulder claim(s), the WCJ explained that "[d]iscussion between the parties and this WCJ at the trial on 10/22/09 had lead this WCJ to the (erroneous) understanding that medical evidence of a cumulative injury to either or both shoulders existed at the time of the Stipulated Award and that [Hancock] had thereby knowingly waived such a claim of injury, by entrance into the Stipulated Award. [Hancock's] Petition for Reconsideration and [SCIF's] Answer have clarified that misunderstanding." The WCJ rejected defendant's argument that Hancock had sufficient knowledge to produce a legally-valid waiver of his shoulder claim. This time defendant petitioned for reconsideration.

Defendant argued Hancock waived his shoulder claim, that it was not a new and further disability, and a petition to reopen was improper without the existence of evidence of a new and further disability at the time of the filing the petition to reopen. The WCJ recommended the Board deny defendant's petition. After repeating his opinion on decision, the WCJ

concluded “the fundamental question is whether a worker may waive something that he has no knowledge of. [Hancock] and this WCJ believe that he cannot. Defendant believes that he can and has. This WCJ believes that defendant is incorrect.”

The Workers’ Compensation Appeals Board denied defendant’s petition for reconsideration. The Board stated Hancock’s “left shoulder injury, and allegedly the right shoulder injury, is a newly disclosed injury which AME Sommer had not commented upon at [the] time the parties entered into the Stipulated Award[.]” Noting Dr. Sommer’s conclusion that the left shoulder problem has an industrial genesis and should be on the list of anatomic parts contributing to Hancock’s disability and for which he should be receiving treatment, the Board concluded the circumstances presented by Hancock’s petition to reopen gave it jurisdiction over his claim, “including the bilateral shoulders by amendment, pursuant to Labor Code §§ 5803, 5804, and 5410.” State Fund filed a Petition for Writ of Review.

State Fund’s petition presented two questions: (1) “Did the Workers’ Compensation Appeals Board err in allowing Hancock’s Petition for New and Further Disability to include body parts that were not part of the original award and were not compensable consequences of the injuries to the body parts of the original award?” (2) “Did the Workers’ Compensation Appeals Board err in rejecting the parties’ stipulation resolving all issues of liability for any injury during Hancock’s entire period of employment with this employer despite no good cause to do so?”

The Court of Appeal granted review and concluded the Board did not err in determining the parties’ stipulation did not preclude Hancock’s petition, but did err in authorizing the reopening of the prior stipulated award to add Hancock’s shoulder injuries. The parties had stipulated in Paragraph 8 of the 2005 stipulated award that: “This agreement resolves all issues of liability for any injury specific or cumulative for plaintiff’s entire period of employment with this employer.” Defendant contends this language was agreed to in exchange for defendant’s acceptance of liability for future medical treatment for Hancock’s left knee and was effective to resolve any and all potential claims of liability, not just “known” claims of liability. Defendant argues the Workers’ Compensation Appeals Board therefore erred in rejecting the stipulation by reopening Hancock’s award. Civil Code §1542 (§1542) provides: “A general release does not extend to claims which the creditor does not know or suspect to exist in his or her favor at the time of executing the release, which if known by him or her must have materially affected his or her settlement with the debtor.”

According to the California Supreme Court, Civil Code §1542 “was intended by its drafters to preclude the application of a release to unknown claims in the absence of a showing, apart from the words of the release of an intent to include such claims.” (*Casey v. Proctor*, (1963) 59 Cal. 2d 97, 109.) Whether the parties intended to release unknown claims is a question of

fact. (*Carmichael v. Industrial Accident Commission*, (1965) 234 Cal. App. 2d 311, 315; see *Jefferson v. Dept. of Youth Authority*, (2002) 28 Cal. 4th 299, 304 [attachment to settlement agreement made it clear the parties intended to settle matters outside scope of workers' compensation] (*Jefferson*); *Gray v. Workers' Compensation Appeals Board*, (1987) 52 Cal. Comp. Cases 536 (writ denied) [applicant's knowledge from medical evidence combined with wording of compromise and release showed intent to release death benefits].) In fact, a number of cases involving workers' compensation releases either note the presence of Civil Code §1542 waivers or discuss the effect of §1542 on releases. (*Jefferson*, supra, 28 Cal.4th at pp. 306-307; *Sumner v. Workers' Compensation Appeals Board*, (1983) 33 Cal. 3d 965, 973, fn. 9; *Gray*, supra, 52 Cal. Comp. Cases 536 [release did not violate §1542 where the wording and evidence indicated an intent to release death benefits].) And while we agree our Supreme Court has been "particularly rigorous about strictly enforcing broad release language in workers' compensation settlements, because in that context, Workers' Compensation Appeals Board oversight helps to ensure fairness[.]" the Supreme Court has at the same time "sought to protect the interests of workers who execute workers' compensation settlement documents without a full appreciation of what claims or rights might later arise." (*Jefferson*, supra, at p. 304.) In the context of workers' compensation, "[a] waiver of a right cannot be established without a clear showing of an intent to relinquish such right, and doubtful cases will be decided against a waiver." [Citation.]" (*Roberson v. Industrial Accident Commission*, (1956) 146 Cal. App. 2d 627, 629.) Here the language of the stipulation is broad, encompassing "all issues of liability for any injury specific or cumulative for plaintiff's entire period of employment with this employer." The Workers' Compensation Appeals Board reviewed the record and found the evidence outside the language of the stipulation insufficient to establish Hancock intended to relinquish his claim of bilateral shoulder injury in the stipulated award because Hancock did not have knowledge that his shoulder problems were industrial until AME Sommer's January 2007 report. We may not re-determine this factual issue because the Board's finding is supported by substantial evidence. (Labor Code §§5952, 5953; *Dept. of Rehabilitation v. Workers' Compensation Appeals Board*, (2003) 30 Cal. 4th 1281, 1290 (Dept. of Rehabilitation); 2 Herlick, Cal. Workers' Compensation Law, 6th ed., 2009, §2 0.04[1], pp. 20-8 to 20-9.)

In his January 2007 report, the AME, Dr. Sommer, noted Hancock had placed symbols on a body image drawing to show pain in his shoulders (principally in his left shoulder) when he first spoke with Dr. Sommer. But Dr. Sommer apparently did not investigate or consider whether Hancock's cumulative trauma injury included his shoulder problems. Dr. Sommer made no mention of Hancock's left shoulder and only included a brief citation to the right shoulder in his 13-page report, on which the stipulated award was based. The stipulated award references only the industrial injuries to Hancock's lower back, knees and carpal tunnels. SCIF points out that prior to the stipulated award Hancock not only knew he had shoulder pain, he remembered a specific work-related incident that injured his left shoulder. He was living

with the continuing symptoms. This is apparently true. In 2007, Hancock told Dr. Sommer that he remembered injuring his left shoulder sometime in the 1990s when he “grabbed the flange of something with his left hand and had a real jerking injury to the left shoulder.” Hancock reported he was briefly off work and then just sort of sucked it up and lived with it since then. Hancock told Sommer it had been a continuing problem that had gotten worse in the last couple of years. If Hancock remembered the work-related incident in 2007, it is likely he knew of it prior to the stipulated award entered in 2005. Nevertheless, it is undisputed Sommer did not opine in his original reports that Hancock’s shoulder injuries had an industrial cause, despite the injuries being pointed out to him. He did not include an opinion on the issue until 2007. Under these specific circumstances, we cannot say the Workers’ Compensation Appeals Board unreasonably found Hancock did not know in 2005 that he had a claim for cumulative trauma to his shoulders. (See *Nielsen v. Workers’ Compensation Appeals Board*, (1985) 164 Cal. App. 3d 918, 927-930; *City of Fresno v. Workers’ Compensation Appeals Board*, (1985) 163 Cal. App. 3d 467, 471-473.) Thus, the Workers’ Compensation Appeals Board was justified in finding that, since Hancock did not know he had an industrial injury to his shoulders when he entered into the stipulation in paragraph 8, there was no clear evidence he intended to waive that claim. The stipulation did not preclude Hancock’s petition to reopen to add his shoulder injuries. The Board did not err in making this finding.

The record in this case, however, does not support the reopening of Hancock’s award. The Board is authorized to reopen a decision or award upon a showing of “new and further disability” (§5410) or for “good cause” (§5803). (*County of San Bernardino v. Workers’ Compensation Appeals Board*, (1981) 125 Cal. App. 3d 679, 684.) §5410 provides an injured worker may “institute proceedings for the collection of compensation . . . within five years after the date of the injury upon the ground that the original injury has caused new and further disability” Under Labor Code §5803, the Board has “continuing jurisdiction over all its orders, decisions, and awards made and entered under the provisions of this division At any time, upon notice and after an opportunity to be heard is given to the parties in interest, the appeals board may rescind, alter, or amend any order, decision, or award, good cause appearing therefor. [¶] This power includes the right to review, grant or re-grant, diminish, increase, or terminate, within the limits prescribed by this division, any compensation awarded, upon the grounds that the disability of the person in whose favor the award was made has either recurred, increased, diminished, or terminated.” (Italics added.) Under §5804, the appeals board retains jurisdiction to rescind, alter or amend an award only where a petition to reopen is filed within five years of the date of injury. We consider each statutory basis in turn.

Defendant claimed that Hancock’s claim of shoulder injury is not a new and further disability that permits reopening of an award under Labor Code §5410. Specifically, SCIF contends the Board erred as a matter of law in allowing Hancock’s petition for new and further disability to include body parts that were not part of the original award and were not

compensable consequences of the injuries to the body parts of the original award. The Court agreed, noting: “Although long the subject of misunderstanding and controversial litigation, it is now clear that Labor Code §5410, and not Labor Code §§5804 [and 5803], control the Appeals Board’s continuing jurisdiction over new and further disability claims.” (*Zurich Insurance Co. v. Workers’ Compensation Appeals Board*, (1973) 9 Cal. 3d 848, 857 (conc. opn. of Sullivan, J.)) Based on the statute’s express language, and the judicial interpretations of that language, the court had no difficulty concluding that a petition to reopen for new and further disability under Labor Code §5410 requires there to be a causal connection between the alleged “new and further disability” and the original industrial injury. Here, nothing in the record supports a conclusion that Hancock’s shoulder injuries, an injury to a new body part, were a compensable consequence of his original injuries. There is no evidence that they were a result or an effect of the industrial injuries to his low back, knees or carpal tunnels. To the extent the Workers’ Compensation Appeals Board relied on Labor Code §5410 in allowing the reopening of Hancock’s stipulated award to include his shoulder injuries, it erred.

Reopening of Hancock’s case was not justified under Labor Code §5803. “[I]rrespective of whether or not there has been ‘new and further disability,’ ‘good cause’ to reopen under Labor Code §5803 may exist.” (*Nicky Blair’s*, supra, 109 Cal. App. 3rd at p. 955; *Beaida v. Workers’ Compensation Appeals Board*, (1968) 263 Cal. App. 2nd 204, 210 [“§5803 is available as an alternate source of supplementary relief”].) The Workers’ Compensation Appeals Board in this case relied on Labor Code §5803 as an alternative basis for permitting the reopening of Hancock’s case. “[I]t is well settled that any factor or circumstance unknown at the time the original award or order was made which renders the previous findings and award ‘inequitable,’ will justify the reopening of a case and amendment of the findings and award.” (*LeBouef v. Workers’ Compensation Appeals Board*, (1983) 34 Cal. 3d 234, 242; see *Walters v. Industrial Accident Commission*, (1962) 57 Cal. 2nd 387, 395; *Aliano v. Workers’ Compensation Appeals Board*, (1979) 100 Cal. App. 3rd 341, 366.) “‘What constitutes “good cause” depends largely upon the circumstances of each case.’” (*Pullman Co. v. Industrial Accident Commission*, (1946) 28 Cal. 2nd 379, 387-388; accord *Nicky Blair’s*, supra, 109 Cal. App. 3rd at p. 955.) “Grounds commonly urged as good cause for reopening are (1) mistake of fact, occasioned by failure or inability to produce certain evidence at a prior hearing; (2) mistake of law disclosed by a subsequent appellate court ruling on the same point in another case; (3) inadvertence, such as when the Board issues a decision under the mistaken impression that a party appearing as a witness had been served with notice of joinder as a party defendant; (4) newly discovered evidence that is more than merely cumulative; and (5) fraud, such as may be perpetrated through perjury and false statements.” (2 Hanna, Cal. Law of Employee Injuries and Workers’ Compensation, Rev. 2d ed. 2010, § 1.04[2][c], pp. 31-16 to 31-17, fns. omitted (Hanna); see *Nicky Blair’s*, supra, 109 Cal. App. 3rd at p. 956.) Similarly, “an award based [on] an executed stipulation may be reopened and rescinded if the stipulation ‘has been “entered into through inadvertence, excusable neglect, fraud, mistake of fact or law, where the facts stipulated have

changed or there has been a change in the underlying conditions that could not have been anticipated, or where special circumstances exist rendering it unjust to enforce the stipulation.” (*Brannen v. Workers’ Compensation Appeals Board*, (1996) 46 Cal. App. 4th 377, 382.) Here the Board stated, “[t]he left shoulder injury, and allegedly the right shoulder injury, is a newly disclosed injury which AME Sommer had not commented upon at [the] time the parties entered into the Stipulated Award[.]” “[I]n order to constitute “good cause” for reopening, new evidence (a) must present some good ground, not previously known to the Appeals Board, which renders the original award inequitable, (b) must be more than merely cumulative or a restatement of the original evidence or contentions, and (c) must be accompanied by a showing that such evidence could not with reasonable diligence have been discovered and produced at the original hearing.” (*Nicky Blair’s*, supra, 109 Cal. App. 3d at pp. 956-957 ; accord, *LeBouef v. Workers’ Compensation Appeals Board*, supra, 34 Cal.3rd at p. 241; 2 *Hanna*, supra, §3 1.04[2][d], pp. 31-17 to 31-18.) Hancock’s petition for new and further disability contains no showing of diligence. In fact, the record before the WCJ and Board suggests a lack of diligence. The evidence reflects Hancock had shoulder pain before the entry of the stipulated award and had indicated such pain to AME Dr. Sommer in his first visit to Dr. Sommer. Hancock remembered a specific incident when he injured his left shoulder at work, which resulted in him taking time off work. He also testified at a deposition that he believed the problems with his shoulder were part of his work-related cumulative injury. Given these circumstances, when Dr. Sommer produced a report that entirely failed to address Hancock’s left shoulder and made only one brief mention of the right shoulder, Hancock, represented by counsel, should have brought to Dr. Sommer’s attention his mistaken omission. Instead, the record reflects Hancock agreed to submit his claim and stipulate to an award based, in part, on Sommer’s existing report. If Hancock had shoulder pain and believed it could be work-related, he should have done something more to obtain a medical opinion regarding its industrial origin. In the absence of evidence of due diligence, there was an insufficient basis for finding good cause to reopen under §5803 on the ground of newly discovered evidence. “While the Workers’ Compensation Appeals Board’s determination of what constitutes ‘good cause’ may be accorded great weight it is not conclusive.” (*Aliano v. Workers’ Compensation Appeals Board*, supra, 100 Cal. App. 3d at p. 366.) “In the absence of ‘good cause,’ the appeals board is powerless to act.” (*Ibid.*) The order of the Workers’ Compensation Appeals Board denying State Compensation Insurance Fund’s petition for reconsideration was annulled and the matter is remanded to the Board with directions to grant reconsideration consistent with this opinion.

COMMUTATION:

VOCATIONAL REHABILITATION:

Colleran v. Workers' Compensation Appeals Board (City of Los Angeles), (2010) 75 Cal. Comp. Cases 1322 (Court of Appeal unpublished) (SEE decision summary at FINDINGS AND AWARD AND ORDERS, above.) (SKIP)

SUPPLEMENTAL JOB DISPLACEMENT BENEFITS:

DEATH AND DEPENDENCY BENEFITS:

Rochelle Gladden (Deceased), Applicant v. State of California, Department of Corrections & Rehabilitation, Workers' Compensation Appeals Board, (2011) Cal. Wrk. Comp. P.D. LEXIS 214 (WCAB Panel). (Spousal dependency presumption not applicable to survivor of an unregistered domestic partnership.)

Defendant sought reconsideration of the Findings And Award And Order of the WCJ, who found that the applicant, Rochelle Gladden, passed away on January 9, 2009 due to her March 4, 2008 stroke incurred as an industrial injury while working for defendant State of California as a parole agent, and that party-in-interest Stella Jacobs was Ms. Gladden's domestic partner and dependent "surviving spouse" pursuant to Labor Code §3501(b), entitling her to an award of death benefits in the amount of \$ 250,000. Labor Code §3501(b) provides as follows:

"A spouse to whom a deceased employee is married at the time of death shall be conclusively presumed to be wholly dependent for support upon the deceased employee if the surviving spouse earned thirty thousand dollars (\$30,000) or less in the twelve months immediately preceding the death."

Pursuant to Labor Code §4702(a)(3), in a case with one total dependent and no partial dependents for injuries occurring on or after January 1, 2006 the surviving total dependent is entitled to a death benefit of \$ 250,000 Defendant contends that §3501(b) does not apply to this case because Ms. Gladden and Ms. Jacobs were not married or registered domestic partners under California law at the time of Ms. Jacobs' death, and that this case should be consolidated with the workers' compensation case involving Ms. Jacobs. The WCJ provided a Report and Recommendation on Petition for Reconsideration in which he recommends that reconsideration be denied, unless the Appeals Board concludes that Ms. Jacobs was not Ms. Gladden's totally dependent surviving spouse, in which case he recommends that the case be returned to him so that he may determine the value of Ms. Jacobs' death benefit as a partially dependent member of the same household.

The WCAB granted reconsideration and ruled that the WCJ incorrectly concluded that Ms. Jacobs was Ms. Gladden's "spouse" within the meaning of Labor Code §3501(b), and she is not entitled to a conclusive presumption of total dependency on that basis. However, the record indicates that applicant and Ms. Jacobs were good faith members of the same household within

the meaning of §3503, and that Ms. Jacobs was dependent upon Ms. Gladden before she incurred her industrial injury. The WCJ had concluded that Ms. Jacobs was entitled to the conclusive presumption of total dependency contained in §3501(b) because she was Ms. Gladden's "domestic partner" and under Family Code §297.5(a) and (c) a domestic partner is to be treated the same as a spouse. The WCAB stated that the problem with the WCJ's analysis is that Ms. Jacobs was not Ms. Gladden's registered domestic partner as required and defined by Family Code §297, which provides in pertinent part that, "A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership." In short, the expansive protections provided in Family Code §297.5 only apply to registered domestic partners, and in this case it is admitted that Ms. Jacobs and Ms. Gladden never registered as domestic partners pursuant to California law. The WCAB also not persuaded that the presumption of Labor Code §3501(b) should apply if Ms. Jacobs and Ms. Gladden were engaged in a "meretricious" relationship as described in various cases cited in the WCJ's Report, including *Marvin vs. Marvin*, (1976) 18 Cal. 3d 660 (Marvin), *Dept. of Industrial Relations vs. Workers' Compensation Appeals Board (Tessler)*, (1979) 94 Cal. App. 3d 72 [44 Cal. Comp. Cases 591] (Tessler) and *State Comp. Ins. Fund v. Workers' Compensation Appeals Board (Donovan)*, (1984) 49 Cal. Comp. Cases 577 (writ denied). Although those cases recognize that individuals engaged in such relationships should not be penalized because of their conduct, no case or court has extended to such persons the full measure of rights and responsibilities that apply to individuals who are lawfully married or registered as domestic partners. The Supreme Court addressed the limitations of the Marvin holding in *Norman v. Unemployment Insurance Appeals Board*, (1983) 34 Cal. 3d 1, where it was held that a woman had not shown good cause for leaving employment in order to follow her fiancé boyfriend to another state, as follows:

"In Marvin, we emphasized the property rights of non-marital partners when their relationship terminated, holding that 'adults who voluntarily live together and engage in sexual relations are nonetheless as competent as any other persons to contract respecting their earnings and property rights ... So long as the agreement does not rest upon illicit meretricious consideration, the parties may order their economic affairs as they choose, and no policy precludes the courts from enforcing such agreements.' As to the marital relationship, however, we carefully emphasized that 'the structure of society itself largely depends upon the institution of marriage, and nothing we have said in this opinion should be taken to derogate from that institution.' The essence of Marvin thus was that non marital partners were not barred by virtue of their relationship from asserting those contractual rights and remedies which are available to other persons.

"Similarly, in [Tessler] the issue was a non-marital partner's entitlement to death benefits...There was substantial evidence that the claimant had been a member of the decedent's household and at least a partial dependent. After reviewing Marvin, and the implications flowing from the repeal of former Penal Code §269a, which had made living 'in a state of cohabitation and adultery' a criminal offense, the appellate court held that the non-marital partner was a 'good faith' member of the deceased employee's household and

dependent upon the employee. The survivor's unmarried relationship with the decedent did not bar her from benefits to which she was otherwise entitled under the statute."

Recent appellate opinions have recognized the limitations of Marvin and have declined to equate a non-marital relationship with marriage. Thus, in *People v. Delph*, (1979) 94 Cal. App.3d 411, the court was examining the term 'spouse' within the 'marital communications' privilege. (Evidence Code §§ 970, 980.) In declining to extend this privilege to non-marital partners, the court accurately characterized Marvin as providing: '. . . a method for equitable resolution of property disputes in situations where the parties not only carried on a relationship that, except for the formal ceremony, was marriage-like. Such relationships have been held not a basis for statutory wrongful death liability. (*Harrod v. Pacific Southwest Airlines, Inc.*, (1981) 118 Cal. App. 3d 155, and in *Garcia v. Douglas Aircraft Co.*, (1982) 133 Cal. App. 3d 890.) Also overnight prison visitation rights were not extended to unregistered domestic partners by Court decision in *In re Cummings*, (1982) 30 Cal. 3d 870.

The court did not reach the question in this case of whether a registered domestic partner is entitled to that presumption because Ms. Gladden and Ms. Jacobs were not registered as domestic partners at the time of Ms. Gladden's death. However, the court did agree with the WCJ that the record supports a conclusion that Ms. Gladden and Ms. Jacobs were good faith members of the same household within the meaning of §3503, and that Ms. Jacobs was partially dependent upon Ms. Gladden. Accordingly, the WCJ's February 28, 2011 decision was rescinded and the case returned to the trial level for a new decision by the WCJ that addresses the extent of Ms. Jacob's dependency and her entitlement to death benefits.

Brezensky v. Workers' Compensation Appeals Board, (2011) 76 Cal. Comp. Cases 1201 (Writ denied). (Death benefits – jurisdictional bar (vs. statute of limitations) for death over 240 weeks from date of injury.)

An application for death benefits was filed by Kathleen Brezensky (widow) on 1/26/10, seeking compensation for injury to Chester Brezensky, Dec'd. At hearing the parties stipulated that decedent sustained an injury on 5/1/2002, that Brezensky's death on 8/31/09 was proximately caused by that injury, and that Kathleen Brezensky was his widow. Defendant contested liability asserting jurisdiction and statute of limitations defenses. There was evidence that two months after her husband's death the applicant became aware that his work injury had aggravated his condition resulting in a myocardial infarction, that it was only then that applicant realized the death was caused by the industrial injury of 5/12/2002. The WCJ ruled that the death claim was timely filed and not barred by the statute of limitations of Labor Code §5406 (c). Defendants sought reconsideration.

The WCJ in his report and recommendation on reconsideration indicated that applicant (widow) had no reason to believe or know her husband's death was due to the 5/12/2002 industrial injury. The WCJ further was the opinion that the crucial element in determining whether the claim is barred is knowledge or becoming aware that the death is work related during and within one year from the date of death or not more than 240 weeks from the date of injury following the date of death. In this case because the applicant filed here claim within one year of the date of death and knowledge as to its cause, her filing was timely.

The Appeals Board granted reconsideration and reversed the finding of the WCJ. The Board concluded that Brzensky died more than 240 weeks from the date of injury, and that the claim for death benefits was therefore barred. The WCAB found that the applicant take nothing on her claim for dependent death benefits. The WCAB indicated that the WCJ erroneously concluded that the 240 week limitation in Labor Code §5406 (c) is a statute of limitation that was tolled until applicant knew that she had a claim for death benefits. The Board noted that the Supreme Court has held that the 240 week limitation period prescribed in Labor Code §5406(c) is not merely a statute of limitations, but was a "legislatively imposed condition that must exist in order for a claim for dependent death benefits to accrue". (*Ruiz v. Industrial Accident Commission*, (1955) ___ Cal. 2d ___; 20 Cal. Comp. Cases 265) The WCAB went on to state that the "date of injury" in Labor Code §5406 may depend on the claimant's knowledge of the nature of the injury causing death, but the date on which the dependent gains knowledge that the injured worker's death was industrially caused is irrelevant if the death occurs more than 240 weeks after the industrial injury because the 240 week time provisions is a condition that must exist in order for any claim for death benefits to accrue. In this case it was admitted that Brezensky died on 8/31/2009, more than 240 weeks after the industrial injury of 5/1/2002. For that reason the WCAB concluded that a claim for dependent death benefits did not accrue. Applicant filed a writ of review which was denied.

SUBSEQUENT INJURIES BENEFITS TRST FUND:

May v. West Valley/Mission College, (2011) 38 C.W.C.R. 244 (WCAB Panel)
(Timeliness of petition for SIBTF benefits.)

WCJ found that applicant was not entitled to subsequent injuries fund benefits because the application for SIBTF benefits was not filed within a reasonable time after the applicant know or should have known that she might be entitled to such benefits. The Workers' Compensation Appeals Board reversed holding that the delay in seeking SIBTF following the receipt of the medical report was not unreasonable based on the complexity of the issue of apportionment and causation. The Workers' Compensation Appeals Board cited the case of *SIF v. Workers' Compensation Appeals Board (Talcott)*, (1970) 2 Cal. 3d. 56; 35 Cal. Comp. Cases 80) which

held the five year limitation period of Labor Code 5410 does not apply to bar claims against SIF filed more than five years after the date of injury.

There is not statutory limitation of the time to file a claim for SIF benefits, but the vacuum has been filled by case law. The court held that were before the expiration of the five year period from the date of injury, an applicant does not know and could not have reasonably know there will be a substantial likelihood he or she would become entitled to SIF benefits, his or her application against the fund will not be barred if he or she files a proceeding against the SIBTF within a reasonable time of after learning the Board's findings on the PD issue that the fund has probable liability. Applying the law to the facts in this case the Workers' Compensation Appeals Board indicated that in this case no PD award ever issue. This case settled by way of a compromise and release. For applicant's back claim on March 26, 2009. The applicant was put on notice of a possible SIF case by a medical report in 2002. In March of 2008 the WCJ issued a decision that the Psyche portion of the case was not the result of an industrial injury. The complex issues of causation and apportionment may well have contributed to the case being settled by compromise and release agreement rather than by a PD award. Applicants delay, the Board found, from receipt of the physicians report in 2002 indicating possible cause of action for SIF benefits was not unreasonable in light of the complex issues.

The SIBT application was filed on December 10, 2008. The application for SIF benefits was in fact filed less than a year after the WCJ decision on applicant's psych claim on March of 2008 finding no psych injury. In summary the Workers' Compensation Appeals Board ruled that no statute compelled it to bar applicants claim for SIBTF benefits as untimely. There had been no award of PD before the claim was filed. There was no evidence that SIBTF was surprised or sustained prejudice. Barring applicants claim would be contrary to the constitutional mandate to provide substantial justice. A claim for SIF benefits will not be barred if the application is filed within a reasonable time after learning of the boards finding on the PD that the fund has probable liability.

PRESUMPTIONS and SPECIAL BENEFITS:

PUBLIC EMPLOYEE DISABILITY RETIREMENT

SERIOUS & WILLFUL MISCONDUCT, LABOR CODE §132a:

Miller v. County of Alameda, (2011) 39 CWCR 208 (WCAB Panel) (Unsupported hearsay insufficient to prove discrimination.)

Applicant sustained injury a result of an automobile accident. Applicant was referred to an AME. The AME first restrictions involving and later removed them saying the applicant could use her best judgment in determining how many hours he could drive and that she could

accommodate all essential job functions. A dispute arose as to whether applicant could continue her job that involved driving. The defendant expressed doubt the applicant was capable of continuing her job and do all necessary driving as long as she could take self-managed ten minute breaks. Applicant filed a petition for increased compensation, asserting discrimination in violation of Labor Code §132a. The parties entered into a stipulation on all the regular issues with a PD of 52%. The matter proceeded to trial on the issue of the claimed violation of Labor Code §132 (a). The defendant at a meeting with her supervisor and someone from told her she could not continue in her job because of her work restrictions. The told her they would look for a job for her within her restrictions, but she would be terminated within 30 days if they could not find an alternative job. She testified she was told by her supervisor several months before that her restrictions on driving would be no problem. She testified that she was aware of a co-employee with driving restrictions of a non-industrial nature much stricter than her who continued to work with those restrictions. She indicated on cross examination that she knew the co-worker had the restrictions until the date of surgery, but she was sure how the defendant was currently dealing with that other situation. She had seen the co-workers restrictions and they were substantially more restrictive than hers. The WCJ found that the defendant had violated Labor Code §132(a). Defendant filed a petition for reconsideration.

The WCAB granted reconsideration. The panel indicated that the AME had opined on March 2, 2009, that in all medical probability it would not be possible for applicant to continue the prolonged traveling to meet clients required by her job. In December the AME recommended modified work but added the subjective preclusions were appropriate that the applicant was able to the best judge her capabilities. Although the applicant testified she continued to work during the spring of 2010 without problems, her treating physician was reporting new symptoms and was recommending a MRI. It was reasonable for defendant to investigate whether applicant could remain on the same job with her increasing symptoms and the restrictions indicated by the physician. Citing the Supreme Court case of *Department of Rehabilitation v. WCAB (Lauher)* (68 Cal. Comp. Cases 831) the WCAB stated that an employer does not necessarily engage in discrimination prohibited Labor Code §32(a) merely because it requires an injured worker to shoulder some of the disadvantages of his or her industrial injury. In enacting Labor Code §132(a) the legislature intended to prohibit treating industrial injured employees differently, making them suffer disadvantages not visited on other employees, because the employee was injured or claimed injury. Although the applicant testified that she was aware of co-workers who were allowed to continue working with driving restrictions, she neither called any co-workers to testify nor produced an evidence of their particular circumstances. Despite the fact hearsay evidence is admissible in proceedings before the WCAB, applicant's testimony about the co-workers physical condition and driving restrictions were too vague to permit comparisons with applicant's situation. Assumptions and uncertainty, the WCAB explained, do not amount to persuasive evidence. The Applicant's testimony was insufficient to establish that she was treated differently from, or made to suffer

disadvantages not visited, on other employees. Having found no discrimination the WCAB found the applicant had not sustained her burden of proof that defendant had violated Labor Code §132(a).

STATUTE OF LIMITATIONS:

SUBROGATION & THIRD PARTY ACTIONS:

PENALTIES, SANCTIONS & COSTS, and CONTEMPT:

Fovos v. L.A. Unified School District, (2011) (39 C.W.C.R. 38 (WCAB Panel)
(Penalty)

The Workers' Compensation Appeals Board reversed the decision of the WCJ that the defendants had not unreasonably delayed payment of the award. The matter was remanded for the WCJ to conduct further proceedings the amount of interest and penalties to which the applicant would be entitled. The panel concluded the record had to be developed because TD must be paid within 14 days, and if payment is untimely the claims administrator must automatically add ten percent to the untimely paid amount. Interest on an award is compensation and if unreasonably delayed delay in payment of interest calls for imposition of a penalty.

Coca-Cola Enterprises Inc. v. Workers' Compensation Appeals Board (Espinoza), (2011) 194 Cal. App. 4th 809; 76 Cal. Comp. Cases 391. (Actual earnings and compensation rate subject to Labor Code Section 4661.5, nor rate provided under Rule 10101.1, controls amount of compensation due on which penalty may be calculated.)

Applicant sustained injury AOE-COE to his shoulders on July 16, 2004. At the time of injury, applicant's earnings were \$1,195.92 per week. Defendant's claims administrator paid two periods of temporary disability indemnity within two years of the date of injury at a rate of \$599.20 per week, and over a year later (three years after the date of injury) paid a lump sum differential correcting the indemnity rate for the periods to the maximum rate for TTD paid within two years of the date of injury, \$728.00 per week. (The Labor Code Section 4661.5 rate for TTD paid over two years after the date of injury is \$797.32 per week.) The WCJ awarded applicant permanent disability benefits and imposed a penalty under Labor Code §5814 for defendants' underpayment of temporary total disability benefits. The WCJ had imposed penalties on temporary disability in three parts: (1) on the first period assuming TTD had been due at \$728 per week; (2) on the second period assuming that TTD was due at \$840 per week, and third on the date of the adjustment, that TTD was due at \$797.32. Defendant sought

reconsideration, claiming that the WCJ and the Board erred by: (1) relying on an incorrect occupational group number in determining Espinoza's PD rating; (2) imposing a penalty under Labor Code §5814; (3) imposing "multiple" penalties on the same type of benefit (TTD); and (4) in calculating the amount of the penalty. The Appeals Board denied reconsideration. Defendant filed a Petition for Writ of Review.

The Court of Appeal granted the petition, only as to one issue relating to the calculation of the penalty. The Court of Appeal held that the WCJ erred in calculating the penalty. Accordingly, they annulled the Board's decision on that point and direct modification of the award. Labor Code §4653 provides that, when a worker is temporarily totally disabled, TTD benefits are payable in the amount of "two-thirds of the average weekly earnings during the period of such disability, consideration being given to the ability of the injured employee to compete in an open labor market." Labor Code §4453, subdivision (a) specifies minimum and maximum limits on the amount of AWEs that may be considered for purposes of this calculation. The limits are different for different time periods, and the limits in effect on a worker's date of injury generally apply. However, under Labor Code §4661.5, when any TTD payment is made two years or more after the date of injury, the amount of the payment is to be computed in accordance with the limits in effect on the date of payment, not the date of injury. (Labor Code §4661.5; see *Hofmeister v. Workers' Comp. Appeals Bd.*, (1984) 156 Cal. App. 3d 848, 852 (*Hofmeister*).)

Labor Code §4650, subdivision (d) provides for an automatic 10 percent penalty on a late TTD payment. In addition, Labor Code §5814 provides for a penalty for an unreasonable delay or refusal of benefits, including an unreasonable failure to pay at the correct rate. Specifically, Labor Code §5814, subdivision (a) authorizes a penalty of up to 25 percent of the amount of the payment unreasonably delayed or refused, or up to \$10,000, whichever is less; this penalty is reduced by the amount of any penalty under §4650, subdivision (d) on the same unreasonably delayed or refused benefit payment. Under Labor Code §4653, Espinoza was entitled to TTD benefits at the rate of two-thirds of his AWEs, subject to the limits in Labor Code §4453, subdivision (a). As noted above, at the time of his injury, Espinoza's AWEs were approximately \$1,195.92 per week. Two-thirds of this amount, as agreed by the WCJ and the parties, is approximately \$797.32 per week.

As the parties stipulated, during the first period of TTD, Espinoza's benefits were capped at \$728, the maximum rate payable on his date of injury, July 16, 2004. (See Labor Code §4453, subd. (a)(9).) However, under §4661.5, for payments made more than two years after the date of injury, including (1) all payments made during Espinoza's second TTD period (October 9, 2006 through February 15, 2007) and (2) the retroactive adjustment payment made on March 21, 2007, the maximum rate payable was the rate in effect on the date of payment, which was at least \$840 per week. (See Labor Code §4453, subd. (a)(10) and Labor Code §4661.5. See

also *Hofmeister*, supra, 156 Cal.App.3d at p. 852.) Because this maximum exceeded two-thirds of Espinoza's AWEs (\$797.32), all payments made during these later periods should have been made at the rate of \$797.32 per week. (See §§4 653, 4661.5.)

The WCJ, however, concluded that, during the first portion of Espinoza's second TTD period (i.e., October 9, 2006 until the provision of the wage statement), Espinoza was entitled to the maximum TTD rate of \$840 per week, even though this exceeded two-thirds of his AWEs. The WCJ based this conclusion on * Cal. Code of Regs §10101.1, which specifies certain materials that must be included in a claims administrator's claim files. Specifically, paragraph (j) of the regulation (regulation 10101.1(j)) requires that a claim file must contain "[d]ocumentation sufficient to determine the injured worker's [AWEs]," information that is necessary to calculate the worker's appropriate benefit level. Regulation 10101.1(j) then states that, "[u]nless the claims administrator accepts liability to pay the maximum temporary disability rate, including any increased maximum due under Labor Code §4661.5, the information shall include" documentation relating to specific matters, such as tips, bonuses, earnings from concurrent employment, and, in some circumstances, the worker's earning capacity.

The WCJ construed regulation 10101.1(j) to "require payment of TTD at the maximum statutory rate unless there is documentation in the claims adjuster's file supporting payment at a lower rate." Because Coca-Cola did not provide Sedgwick (the claims adjuster) with a wage statement documenting Espinoza's actual wages until at least November 2, 2006 (the date on the wage statement), the WCJ held that regulation 10101.1(j) required defendants to pay Espinoza the maximum statutory rate until the wage statement was received. The WCJ thus concluded that, for the period from October 9, 2006 until provision of the wage statement, defendants were obligated to pay \$840 per week, the statutory maximum then in effect. (Once the wage statement was received, the rate due was \$797.32 (two-thirds of Espinoza's AWEs).) Accordingly, in computing the portion of the \$5814 penalty attributable to the period from October 9, 2006 until the provision of the wage statement, the WCJ imposed a penalty of 25 percent of the difference between \$840 per week and \$599.20 per week (the amount paid). The Court disagreed with the WCJ's construction of regulation 10101.1(j). The regulation does not state that a worker is entitled to receive, or that an employer is obligated to pay, TTD at a rate higher than two-thirds of the worker's AWEs, the benefit level set by Labor Code §4653. Instead, as discussed above, regulation 10101.1(j) imposes recordkeeping requirements on claims adjusters; it does not purport to address the benefit levels owed to workers. The first sentence of regulation 10101.1(j) states a general requirement that a claim file contain documentation sufficient to determine the worker's AWEs.

The court declined to construe regulation 10101.1(j) as imposing what in effect would be an additional penalty, payable to the injured worker. Because Espinoza was entitled to TTD

benefits of \$797.32 (rather than \$840) per week during the period from October 9, 2006 until the provision of the wage statement (as well as during the remainder of his second TTD period), the portion of the Labor Code §5814 penalty attributable to that period should be recalculated.

The Board's decision is annulled only as to the calculation of the portion of the Labor Code §5814 penalty attributable to the period from October 9, 2006 until the provision of a wage statement. In recalculating that portion of the penalty, the Board or the WCJ shall base the penalty amount on the difference between \$797.32 per week and \$599.20 per week. The Board's decision is otherwise affirmed. The defendant's petition for review was summarily denied as to all other issues raised in the petition, as of the date of finality of this opinion. Espinoza's request for attorney fees under Labor Code §5801 was denied.

Dominguez v. Workers' Compensation Appeals Board, (2011) 76 Cal. Comp. Cases 811 (Writ Denied) (No sanction for timely UR, even if decision later reversed.)

Applicant sustained an admitted injury to his right hand, right wrist and right lower extremity. The treating physician requested a demagogical consult because the applicant developed a rash around the site of the injury. The consult request was sent to UR and denied on 2-5-10. On 2-23-10 the consult was authorized. The applicant filed a petition for sanctions based on the initial UR denial. The request for sanctions was denied following trial by the WCJ. Applicant filed a Petition for Reconsideration contending that the UR was not timely the UR was performed by an unqualified physician because the UR physician was an anesthesiologist and had no expertise in dermatology or orthopedics. The WCJ in his report indicated that sanctions pursuant to Labor Code §5813 are awarded if a party engages in bad faith actions, or tactics that are frivolous or solely intended to cause delay. The WCJ found in this case that defendant's actions to not rise to the level required by Labor Code §5813. The WCJ found the UR request based on the facts of the case was timely. The WCJ further found even if it was not done timely there still would be no basis to impose sanctions, since there is nothing to indicate that untimely UR would result in a penalty pursuant to Labor Code §5814, or is a sanctionable action under Labor Code §5813. The WCJ also pointed out the treatment was ultimately authorized. The WCJ found that there was no substantial evidence to indicate that the doctor did not meet the requirements of Labor Code §4610(e) in connection with licensing or competency to evaluate applicant's condition based on his area of expertise. Further the WCJ indicated that there was no showing that lack of qualifications of the UR physician could be the basis for sanctions pursuant to Labor Code §5813. The WCJ concluded that the defendants acted properly in responding to the treatment requests of the treating physician. The actions of the defendants were not in bad faith actions, or tactics that are frivolous or solely intended to cause delay. The WCJ found no basis to award actions.

The WCAB adopted the report and recommendation of the WCJ and denied reconsideration. The writ was denied.

In Re Escamilla, (2011) 76 Cal. Comp. Cases 944 (WCAB En Banc) (Suspension of non-attorney representative's right to appear.)

The Appeals Board gave notice of hearing on the issue of suspension from right of appearance of a lien representative, Daniel Escamilla, after he had been repeatedly sanctioned for engaging in bad-faith actions or tactics that are frivolous or solely intended to cause unnecessary delay. Specifically, in eleven matters between August 2003 and June 13, 2011 Mr. Escamilla had been sanctioned \$13,050 in ten cases and ordered to pay costs and fees to opposition in excess of \$50,000.00 in four cases. The imposition of costs and sanctions appeared to have been ineffective in curbing Mr. Escamilla's pattern of misconduct.

At a Commissioners' Conference in 2009, Mr. Escamilla had been warned and acknowledged that "if he failed to act in conformity with the State Bar Rules while acting as a hearing representative before the Appeals Board and WCJs his privilege of appearing as a hearing representative could be suspended or removed." The Board then described conduct of Mr. Escamilla in three matters in which he misrepresented identity of his principal(s), misrepresented material facts in petitions for reconsideration, and falsely alleged contacts and agreements which the preponderance of evidence indicated had not occurred with a defendant.

On November 7, 2011, Mr. Escamilla filed a Petition for Reconsideration appealing the September 21, 2011, Notice of Hearing. On January 4, 2012 the Appeals Board en banc dismissed the petition as neither timely nor taken from a final decision order or award, and on January 20, 2012 dismissed other petitions, but allowed dismissal of counsel for Mr. Escamilla and continuance of the hearing on the merits of the charges.

Fryer v. Travelers Insurance Co., (2011) 39 C.W.C.R.207. (Sanction for failure to authorize WCJ ordered treatment.)

Applicant sustained a back injury on January 2, 1997. In 2000 applicant was determined to be permanent and stationary, and received an award of further medical treatment for his back injury. In 2009 applicant selected a primary treating physician not a member of defendant's MPN. Defendant refused to authorize treatment by the non-MPN physician. After an Expedited Hearing the WCJ found by decision of August 19, 2010, (1) that defendant had lost the right to require applicant to treat within the MPN and (2) that applicant was authorized to select and treat with a non-MPN physician. It was also found (3) that applicant's physician of choice, Dr. Nicodemus, was the primary treating physician, and (4) ordered payment of certain

medical bills. Defendant sought reconsideration, but its petition did not challenge the determination that defendant had lost its right to compel treatment within the MPN. Before the petition for reconsideration was denied, on September 29, 2010, defendant advised Dr. Nicodemus and applicant by letter that only continuity of care treatment was authorized; no further treatment by Dr. Nicodemus would be authorized. Applicant sought sanctions.

At hearing on January 11, 2011, defendant's adjuster testified that she attempted to perfect the previously defective MPN notices and transfer applicant's treatment into the MPN. After hearing the WCJ Imposed four \$2,500.00 sanctions upon defendant for (1) by advising Dr. Nicodemus by letter that it was denying liability for further treatment after the August 19, 2010 decision; (2) by advising Mr. Fryer by letter that it was denying liability for further treatment after the August 19, 2010 decision; (3) by failing to pay for an MRI ordered by Dr. Nicodemus, and (4) for failing to adjust or pay a hospital bill. Defendant sought reconsideration.

The Appeals Board granted reconsideration and held that the defendant's failure to comply with the August 19, 2010 decision was sanctionable misconduct. (*All Tune and Lube v. WCAB (Derboghosdsian)*, (2006) 71 Cal. Comp. Cases 795 (writ denied).) The failure of defendant to challenge, in the petition for reconsideration, the WCJ rulings that treatment outside the MPN was authorized and that Dr. Nicodemus was applicant's PTP made those determinations final at the time of the September 29, 2010 letters. The WCAB panel, however, reduced the overall sanction amount to \$2,500.00.

Montalvo v. Adir Restaurant Corp., (2011) 39 C.W.C.R. 295 (WCAB Panel Decision) (Sanctions for failure to serve C&R on lien claimants / failure to prove delegated service, amount of sanction for either defendant's failure to serve / prove service, or on lien claimant for failure to acknowledge service and appear.)

Workers' compensation liability of the self-insured employer to applicant for a work injury was settled by a Compromise and Release approved, with defendant directed to make service of the settlement on all other parties, including outstanding lien claimants. Thereafter a lien conference was noticed and held. Aminian, a lien claimant failed to appear at the lien conference, and a Notice of Intention to Dismiss the Lien for failure to appear issued. No response was filed within the time allowed, and on August 1, 2011, the WCJ ordered the lien dismissed. On August 8, 2011, the WCJ received lien claimant's objection, alleging that it had assumed that the hearing was on issues in the case in chief. No action was taken on the objection, and lien claimant filed a timely Petition for Reconsideration.

The Appeals Board granted reconsideration. It set aside the order dismissing the lien, finding that under current law and regulations it is essential to know whether defendant had or had not made service of the settlement and Order Approving Compromise and Release. No proof of service of the documents was on file. On remand the WCJ was directed to allow defendant opportunity to file proof of service on lien claimant of the settlement and Order

Approving Compromise and Release. If such service was shown, the lien claimant is to be sanctioned \$500.00 for failure to attend the lien conference and its frivolous appeal; if such service is not shown, defendant is to be sanctioned \$500.00 for violation of Rules of Practice and Procedure §10886.

WORKERS' COMPENSATION FRAUD

People v. Svercsics, (2011) 39 C.W.C.R. 285 (Court of Appeal, unpublished opinion.) (Fraud for failure to disclose prior injury; extent of restitution.)

Svercsics, of Hungarian background, sustained work injuries to his low back in 1995 and 1998. His claim for the earlier injury was resolved by \$15,000.00 compromise and release. The 1998 injury resulted in an award including permanent disability indemnity of \$18,000.00. Svercsics sustained a further back injury in 2005, and in medical history and deposition testimony disclosed the 1998 injury but not the 1995 injury.

Svercsics was charged with three counts of workers' compensation insurance fraud (violation of Ins. Code §1871.4 for false statements in medical histories to physicians, on a medical history questionnaire, and in deposition testimony. He contended his intent was not to defraud, but resulted from limited understanding of English, and a notion that he only needed to disclose injuries occurring in the preceding 10 years. He was convicted sentenced to 180 days incarceration, five years probation, and ordered to pay \$9,500.00 in restitution. His appeal was denied, and the order to make restitution of \$9,500.00 of the compensation insurer's \$12,531.21 in investigation costs was affirmed. The Court noted that the restitution amount was set pursuant to stipulation, and had it been for \$10,000.00 or more, Svercsics would have been subject to deportation.

ARBITRATION AND CARVEOUTS:

ATTORNEYS & ATTORNEY'S FEES

WORK PRODUCT / PRIVILEGE

Coito v. Superior Court of Stanislaus County, (2010) 182 Cal. App. 4th 758; 75 Cal Comp. Cases 240 (Review Granted --Opinion not citable). (Discovery – work product.)

Plaintiff's 13 year old son drowned in the Tuolumne River in Modesto on March 9, 2007. A wrongful death action was filed against the State of California, Department of Water Resources. In 2008 the Attorney General's office, representing Department of Water Resources, sent two investigators, with a set of questions drafted by counsel to interview four juveniles who had witnessed the drowning. The investigator recorded each witness' statement on a compact disc, and prepared a written summary for the Deputy Attorney General. The interview content was used as a basis for deposition of one of the witnesses taken by counsel

for City of Modesto in January 2009. Plaintiff's counsel demanded production of the four witness' statements, but not the investigator's summaries. The Attorney General's office objected, claiming the statements were work product. After a hearing on the discovery motion, the trial court ruled that the identities of the witnesses was not subject to production in response to interrogatory, and that the interview recordings were entitled to absolute work product protection from discovery. Plaintiff filed a writ of mandate to compel production.

The Court held that the work product privilege in California is codified in §§2016.010 et. seq. of the Code of Civil Procedure. There are two levels of work product privilege – absolute and qualified. Writings that reflect an attorney's theories, opinions, legal research, tactical plans, or conclusions are absolutely privileged. Qualified work product privilege is not defined by statute, but has developed in case law. The decisions rely on the distinction between derivative or interpretive material [which is to be protected] on one hand versus evidentiary or non-derivative material. In the latter category a statement prepared by a witness does not become work product by transmittal of the statement to an attorney. Generally the text of statements taken from independent witnesses by an adjuster or investigator is discoverable; the notes reflecting impressions, conclusions, inferences, and commentary on the statements are protected. Here, even though the lie of inquiry of the witnesses was prepared by counsel, the witnesses statements are evidentiary in nature, and may be used at trial to refresh recollection or impeach inconsistent testimony. Here the Court in a 2 to 1 decision found that the state had failed to show that the statements taken revealed plans, theories, impressions or conclusions of counsel subject to protection, and the Court ordered the statements produced. The DISSENTING judge was of the opinion that, where the witnesses identities were known (without resort to discovery) the statements disclosing the particular questions or issues the attorney pursued should be protected unless such protection would unfairly prejudice the party seeking discovery. (**Opinion is not citable** – Review granted June 9, 2010.)

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