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**SUMMARY OF
RECENT SIGNIFICANT DECISIONS IN
CALIFORNIA WORKERS'
COMPENSATION LAW**

JANUARY 2007 - JANUARY 2008

DISCLAIMER

In this case law summary, the author has attempted to present an accurate summary of each case. However, at least to some extent, the summaries are dependent on the interpretation of the author, and cases are often subject to more than one interpretation. Furthermore, the reader should review the actual cases before citing them as authority since the summaries may contain errors, and cases are subject to being revised by the Courts after publication of the case law summary.

The opinions and analyses presented in this case law summary are those of the author and are not to be attributed to the Division of Workers' Compensation, the Workers' Compensation Appeals Board, or any other Workers' Compensation Administrative Law Judge.

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**Summary of
Recent Significant Decisions in
California Workers' Compensation Law
January 2007 – January 2008**

I. Jurisdiction and Venue

Gallo v. WCAB (2007) 72 CCC 1474, Court of Appeal, Fifth Appellate District, unpublished opinion.

Based on the opinion of an AME, the WCJ concluded that Applicant, *in propria persona* at the time of the trial, was 43 percent permanently disabled, less 25-1/4 percent attributable to a prior Award, and deferred the issue of how the apportionment should be calculated pending the outcome of litigation before the Supreme Court. The WCJ also declined to consider new medical evidence offered by Applicant at the trial, after discovery had closed at the MSC.

Applicant's Petition for Reconsideration was denied. Eight days later, Applicant wrote a "To Whom it May Concern" letter to the Appeals Board acknowledging receipt of the Order Denying Reconsideration and voicing various dissatisfactions with the decision and the insurance carrier. Thereafter, the WCJ issued a Supplemental F & A calculating Applicant's level of apportioned disability. The Supplemental Award contained the notation it was "Filed and Served by Mail on 8/14/07 on parties listed on the Official Address Record." Applicant then filed a Petition for Writ of Review 133 days after the Order Denying Reconsideration and 50 days after the WCJ's Supplemental Award.

Although it was unclear from the petition whether Applicant was claiming that he never received the Appeals Board's denial of reconsideration or that he never received the WCJ's Supplemental F & A, the Court of Appeal found that in either event, it was without jurisdiction to review the matter. Applicant acknowledged receipt of the Order Denying Reconsideration in his "To Whom It May Concern" letter and his petition filed more than 45 days later was therefore untimely. Even if he didn't timely receive the Supplemental F & A, a Petition for Writ of Review cannot be filed unless the WCAB, on its own motion or in response to a Petition for Reconsideration, has granted or denied reconsideration of the final order, decision, or award. Thus, the Petition for Writ of Review was denied.

Garcia v. Helmsman Management Services, Inc. (2007) 72 CCC 53, Court of Appeal, Second Appellate District, unpublished opinion.

Applicant received a Stipulated Award in 1985 with provisions for future medical treatment. Beginning in 2004, the employer's third party administrator refused to pay for

his medical treatment. Applicant filed a complaint in Superior Court against both the employer and the TPA for breach of contract and bad faith. The trial court sustained the TPA's demurrer without leave to amend, and entered a judgment of dismissal. Applicant appealed the judgment.

The Court of Appeal found that the conduct that formed the basis for Applicant's complaint had been found by the Supreme Court to be within the exclusive jurisdiction of the Appeals Board, and that his remedy is set forth in Labor Code §5814. The Court declined to give Applicant an opportunity to amend the complaint because in order to do so, he would have to allege that the TPA engaged in wrongful acts that did not involve a normal insurer activity, specifically the processing of medical claims. Therefore, the judgment of dismissal was affirmed.

II. Employment

Heiman v. WCAB (Aguilera) (2007) 72 CCC 314, Court of Appeal, Second Appellate District, Division Three, published opinion.

Petitioner, Heiman, individually and doing business as Pegasus Properties, entered into an agreement with an unincorporated association of residential condominium owners to manage the property and arrange for repairs of the common area. Pegasus hired Hruby, an unlicensed, uninsured contractor to install new rain gutters. Hruby hired Applicant who was seriously injured on the first day of the job. Applicant filed an Application for Adjudication naming Hruby and the UEBTF, Pegasus, the Association and the individual condominium owners as defendants. The WCJ determined that Hruby was Applicant's employer and was liable for workers' compensation benefits, including 90 percent permanent disability. Even though Hruby could not be considered to be an independent contractor since he was unlicensed, the WCJ found that the owners could not be employers because Applicant lacked sufficient hours. He also found that the agents, whether the Association or Pegasus, would be entitled to the rights and liabilities of the owners and should be deemed owners. Applicant petitioned for reconsideration contending that the Association was liable and that he was 100 percent disabled.

The Appeals Board granted reconsideration and held that Hruby could not be Applicant's employer because he was unlicensed. Since Hruby had been hired by Pegasus, it was found that Pegasus was liable for workers' compensation benefits. The Appeals Board also ordered further development of the record in connection with Applicant's permanent disability claim.

Heiman/Pegasus sought judicial review, contending the WCJ was correct that it was the agent of the Association or the owners, and not liable under Labor Code §§3351(d), 3352(h) and 3715(b). In its answer, the UEBTF argued that §§3351(d) and 3352(h) were inapplicable since Pegasus was not an owner and even if even if Pegasus was the agent of the owners or the Association, it would then be the joint employer since Pegasus hired Hruby. Applicant answered that the Association may be liable because Pegasus hired Hruby on behalf of the Association.

The Court of Appeal noted that among the legal consequences of hiring an unlicensed contractor work is that different employment relationships may arise with respect to “employer” liability for workers’ compensation. However, the owner or occupant of a *residential* dwelling, who hires an unlicensed contractor whose employee is injured, may not be the “employer” liable for workers’ compensation unless the employee worked sufficient hours under Labor Code §3352(h). The Court therefore concluded that Hruby was a dual employer of Applicant because Hruby hired him and he rendered the services as an employee and not as an independent contractor.

The Court found that the agreement for installation of the rain gutters was between Hruby and Pegasus which was an independent contractor in the business of managing properties that was acting on behalf of the Association. Therefore, Pegasus was an employer and jointly and severally responsible for workers’ compensation.

The Court agreed with Pegasus that it was an agent of the Association, but disagreed that as an agent, it had the same legal status as an owner and was therefore exempt under the hours requirement of Labor Code §§3351(d) and 3352(h). It also disagreed that the Association was exempt as owners since it had corporate powers to finance, contract and conduct business. Consequently, the duties performed by Hruby and Applicant were not “personal” and were in the “trade [or] business” of the Association. Therefore, the Association was liable for workers’ compensation as the principal of Pegasus. On the other hand, the Court found that the owners weren’t liable because Applicant did not work sufficient hours under §3352(h).

The Court held that Hruby was jointly and severally liable with Heiman/Pegasus, and that the Association was also liable as Pegasus’ principle. To the extent that Appeals Board’s decision was inconsistent with that conclusion, it was annulled.

III. Insurance Coverage/California Insurance Guarantee Association

California Insurance Guarantee Association v. WCAB (Hernandez) (2007)
72 CCC 910, Court of Appeal, Second Appellate District, Division Six,
published opinion.

Applicant suffered a specific injury and subsequently sustained a cumulative trauma to the same body part. The carrier insuring the first injury became insolvent while both claims were pending, and was succeeded by CIGA, while a different carrier was responsible for the CT. Nonetheless, CIGA paid for all the non-permanent disability indemnity benefits, for both injuries. After a joint C & R, CIGA filed a Petition for Contribution to recover from the solvent carrier the entire sum of benefits it had paid. The matter was referred to arbitration.

The arbitrator found in favor of CIGA because the carrier was a solvent “other insurer” that was jointly and severally liable for the full amount at issue for both claims. However, the Appeals Board granted the solvent carrier’s Petition for Reconsideration and, based on the opinion of the AME, determined that 75 percent of the temporary disability was

due to the specific injury and 25 percent to the CT. Subsequently, the arbitrator found that the solvent carrier should be responsible for contributing 25 percent of the amount paid by CIGA. The Board denied further reconsideration and CIGA sought judicial review.

The Court of Appeal first noted that CIGA is not an insurer and that it is a creation of the Legislature. CIGA's role is limited to paying only the amount of "covered claims" of an insolvent insurer. Insurance Code section 1063.1, subdivision (c)(9) provides: "Covered claims does not include (i) any claim to the extent it is covered by any other insurance," The solvent carrier contended that Labor Code §§3208.2 and 5303, the so-called "anti-merger" statutes precluded joint and several liability for the entire cost of the temporary disability. However, the Court noted, the real purpose and function of these two sections, was to preclude an employee from escaping the statute of limitations by attempting to merge a purported prior injury for which no timely Application was made with a timely, current claim.

Since "other insurance," was available, CIGA was statutorily prohibited from making any payment towards the Award. The Legislature did not intend CIGA to defray or diminish the responsibility of other carriers. Even if Applicant had elected to proceed against a solvent insurer for all his benefits, that insurer would have been obligated to pay the entire award and could not institute proceedings against CIGA for contribution.

The appellate decisions in *CIGA v. WCAB (Weitzman)* and *CIGA v. WCAB (Hooten)* that solvent carrier with joint and several liability must reimburse CIGA in full for all the temporary workers' compensation benefits it paid. Between workers' compensation insurers who are jointly and severally liable for various temporary benefits, there is generally pro rata apportionment for the shared liability. But, CIGA is not another workers' compensation insurer; it is a fund with responsibilities that are limited by statute in order to insure that the worker is protected. CIGA does not protect workers, not insurers.

Accordingly, the Board's decision was annulled and the matter remand with directions for the Board to enter a new and different decision requiring the solvent carrier to reimburse CIGA for 100 percent of its outlay for the temporary benefits at issue.

IV. Injury AOE/COE**A. In General**

City of Los Angeles v. WCAB (De Leon) (2007) 72 CCC 1463, Court of Appeal, Second Appellate District, Division Three.

The deceased employee, an accountant, died as a result of a fall while he was attending a CPA convention in Atlantic City, New Jersey. The WCJ found that the defendant encouraged its accountants to maintain a CPA license through a salary bonus; that the employee would not have been in Atlantic City but for the work related need to maintain his license; and that his death was therefore industrial based on commercial traveler principals. Alternatively, the WCJ reasoned that the claim came under the special mission exception to the going and coming rule since participation in continuing professional education classes was undertaken at the implied request and encouragement of the employer and was a special requirement that was not part of regular work duties. In a split decision, the Appeals Board panel denied reconsideration, adopting the report of the WCJ. Defendant then sought judicial review.

The Court first noted that an off-the-premises injury is within the course of the employment if it is sustained while the employee is doing those reasonable things that his contract of employment expressly or impliedly authorizes him to do. Addressing the commercial traveler doctrine, the Court felt that the WCJ gave undue weight to the bonus. The defendant didn't benefit from CPA licensure and provided the training that is accountants needed to do the job. The bonus was a reward for going above and beyond the requirements of the employment.

Regarding the applicability of the special mission exception to the going and coming rule, the defendant did not request or invite the employee either to obtain a CPA license or to travel to Atlantic City. Not only was the trip not a special mission. It was not an ordinary commute either. Rather it was voluntary and personal. Therefore, the Board's decision was reversed and remanded for further proceedings consistent with the Court's decision.

Bakersfield City School District v. WCAB (Boyd) (2007) 72 CCC 1191, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant's job for a public school district required him to travel between school sites. While stopped at a traffic light within several blocks of four schools, he noticed a man across the street running away from a police officer. Concerned that the suspect may have tried to run to one of the nearby schools, Applicant got out of the truck and tried to block the runner's path. In the process, he tripped over the curb and landed with his arm extended, injuring his right shoulder.

After a trial, the WCJ found that the injury was not AOE/COE, finding Applicant's testimony to be "disingenuous" regarding his belief that he was acting to protect student

safety in aiding the police. However, on reconsideration, the Appeals Board reversed. Defendant then sought judicial review.

While acknowledging that the credibility determination of the WCJ are entitled to great weight, the Court pointed out that the Appeals Board is entitled to reject that determination “if substantial evidence supports contrary findings.” However, the Board did not based its decision on credibility alone. In its decision, it cited a number of cases to illustrate the following principle:

“Injury sustained by an employee acting in response to an emergency or other situation, whether it is classified as a rescue, response to an emergency, or exercise of common decency, is within the course of employment.

Although the facts of the current case differed somewhat from the facts underlying the cited cases, the Court noted that it would be impossible to list all of the acts that employees can and cannot do in the course of their employment. Therefore, the Petition for Writ of Review was denied.

City of Turlock v. WCAB (STK09 YYZZZ) (2007) 72 CCC 931, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant worked as a utility maintenance worker in Defendant municipality’s sewage system for 16 years during which he was exposed to raw sewage on a daily basis. He contracted hepatitis C and asserted a workers’ compensation claim, alleging a causal connection between the hepatitis and his job. The matter came on for trial and Applicant credibly testified to his exposures. The WCJ found the compensable opinion of Applicant’s QME to be much more persuasive than that of the Defendant’s QME who did not find an industrial injury. The Appeals Board denied reconsideration, adopting the WCJ’s reasoning.

Defendant sought judicial review, contending that the opinion of Applicant’s QME did not constitute substantial evidence. The Court noted the record contained two conflicting medical opinions: one finding that hepatitis C is transmittable via human waste and raw sewage, and another opinion finding insufficient medical literature to support such a conclusion. Defendant’s QME, however, offered no alternative explanation for Applicant’s contraction of the disease in light of the nonexistence of any other risk factors and did not review the medical studies that demonstrated a causal connection. Therefore, the Appeals Board’s decision was supported by substantial evidence.

The Court remanded the matter to the Appeals Board to issue a Supplemental Award to Applicant’s counsel for legal services rendered in answering the petition.

Toshi v. WCAB (2007) 72 CCC 420, Court of Appeal, Third Appellate District, unpublished opinion.

The deceased employee sustained an industrial back injury in 2000. In 2003, he committed suicide by hanging himself. His common-law wife asserted a workers' compensation death claim on behalf of their minor child on the ground that his suicide was the result of an irresistible impulse, proximately caused by his industrial injury.

The employee had a number of nonindustrial stressors in his life. Before meeting his wife, he had a child with a woman in Germany whom he abandoned. According to his brother, he had fallen off a donkey and injured his back many years before. The same brother reported that he abused alcohol. According to his widow, he regularly beat her before moving to the United States in 1998. When she went to work in 2002, he became possessive and jealous. In seeking a restraining order in March 2003 she stated: "He grabbed a knife and held it up to my throat. He beat me -- punched me, kicked me, called me names. He also grabbed me by the throat, strangling me with his hands." In the three months before his death, he was incarcerated twice and attempted suicide twice. He drank heavily. He complained to a neighbor about his chronic back pain.

The Appeals Board found that the decedent's suicide was not the result of an irresistible impulse caused by an industrial injury. Applicant sought judicial review of this decision.

The Court noted that Labor Code §3600(a)(6) prohibits recovery of workers' compensation benefits if the employee "willfully and deliberately" caused his own death. However, where the suicide is directly caused by the employee's injuries and their consequences, and he kills himself under compulsion of an irresistible or uncontrollable impulse, his death is not intentionally self-inflicted or willful so as to bar compensation.

Applicant had obtained a medical opinion that the employee's death by suicide was compensable because the pain and loss of his family that resulted from his industrial injury caused him to feel that death would afford the only relief. Defendant's QME acknowledged that the injury had aggravated the depression, worry, and changes in the decedent's life circumstances, but did not precipitate it, nor predominantly cause it. He concluded that Applicant's family problems were clearly predominant. The Board had noted that the decedent's mental health and jail records all supported the opinion of the defendant's QME. Thus, the Court found ample evidence to support the Board's decision.

Elmore v. WCAB (2007) 72 CCC 8, Court of Appeal, Fifth Appellate District, unpublished opinion.

After being notified that his employment would be terminated, Applicant filed an Application for Adjudication, alleging that while reaching out to type a report, he felt pain in his upper back going down his arm to his fingertips. At the time, he had not worked for nine months. At trial, he testified that he was injured when he fell at work. Defendant's human resources manager testified that on his last day of work, Applicant reported pain from an old Vietnam injury and that she assisted him in filing for SDI. The

WCJ found that his testimony lacked credibility and that the injury was otherwise barred under Labor Code §3600(a)(10) as having been filed after notice of termination.

Applicant dismissed his attorney and filed a Petition for Reconsideration on the basis of newly discovered evidence. He explained that he was unable to remember the facts surrounding the accident until he underwent testing at medical center four month after he left work. The Appeals Board agreed that his claim was not barred by the post-termination exclusion, but also agreed with the WCJ's credibility determination and noted that the petition could be dismissed because Applicant failed to verify and serve it on Defendant. Applicant then petitioned for judicial review.

Since Applicant only raised the issue of whether the Appeals Board properly denied his Petition for Reconsideration, the Court of Appeal presumed he was contending that the Board's finding that he did not sustain an industrial injury lacked substantial evidence. In denying the Petition for Writ of Review, the Court noted that Applicant did not offer any medical opinion that his injury was work-related. Instead, he merely presented evidence that he posed the possibility of an industrial injury to his treating surgeon which was not confirmed by the doctor's response that a fall "could exacerbate" his condition. Furthermore, the Court was bound by the Board's determination that Applicant's testimony was not credible and that the testimony of Defendant's witness was credible. Lastly, the Court noted that the Petition for Writ of Review was not verified, in violation of Code of Civil Procedure §1069.

B. Going and Coming Rule

Lamers v. WCAB (2007) 72 CCC 599, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant's deceased husband was hired as a security guard with the understanding that that full-time employment was not then available, but that the company would send him to different worksites for training and to assess his suitability. He was assigned to a bridge worksite for which there was no bus service, but which was located about an hour by car from his residence. The assignment did not require the use of a car or a driver's license as the job duties involved walking along the bridge. He was killed in an automobile accident on his way to the bridge on the first day of his assignment. The WCJ denied the widow's claim for death benefits on the ground that it was barred by the going and coming rule, and the Appeals Board affirmed that decision.

Applicant petitioned for judicial review, relying on language in *Hinojosa v. WCAB* (1972) 37 CCC 734, that the going-and-coming rule precludes workers' compensation recovery if "the injury occurs during a local commute en route to a *fixed place of business at fixed hours* in the absence of special or extraordinary circumstances." She argued that the rule did not bar recovery in her case because her husband did not have an established worksite and his hours varied day to day. She also contended that as in *Hinojosa*, her husband fell within the "transportation exception" to the going-and-coming

rule by conveying a special benefit to the employer by driving his personal vehicle to the bridge on the day of his assignment.

The Court of Appeal distinguished this case from *Hinojosa* by observing that here, the deceased employee knew in advance when and where he would work on any given day and was not required to transport himself from one jobsite to another during an assignment. Furthermore, there was no evidence that a vehicle was necessary to perform the job duties and as the Appeals Board had noted: “It would be inequitable to find that an injury sustained by one employee is compensable, while an injury sustained by another employee is not, merely because the first employee had a longer commute. Thus, the Court denied the Petition for Writ of Review.

Rash v. WCAB (2007) 72 CCC 614, Court of Appeal, Fifth Appellate District, unpublished opinion.

As a deputy sheriff who was member of the employer’s horse-mounted unit, Applicant was required to privately own, care for, train, and transport a horse certified for mounted duty to be available for service 24 hours a day, seven days a week. Applicant’s commander adopted a constant shoeing requirement so that horses approved for mounted duty would be ready at a moment’s notice. Applicant enrolled in a horseshoeing class at the request of his commander. Subsequently, he was asked to cover the shift of another mounted deputy at a rodeo the following weekend. When he examined his horse certified for mounted duty, he discovered its right rear shoe was missing.

Applicant decided to shoe his horse at the class because he believed it would be quicker and more reliable than trying to schedule a farrier in time for the rodeo. After all four of the horse’s shoes were replaced, he loaded the horse into his privately owned truck and trailer, stopped for lunch, and then proceeded down the highway to his home. On the way, another vehicle struck him head-on and he sustained multiple injuries. The employer denied his claim for workers’ compensation benefits and the WCJ agreed. On reconsideration, the Appeals Board adopted and incorporated the report and recommendation of the WCJ.

The Court of Appeal reviewed the case law governing the determination of whether an injury arises out of and in the course of employment, including the special mission exception to the Going and Coming Rule. Noting that the burden of proving AOE/COE falls on the employee and generally presents a question of fact to be determined in light of the circumstances, the Court went on to state the where the pertinent facts are not in dispute, resolution of the question becomes a matter of law subject to de novo appellate review.

The WCJ had found that the injury arose out of the employment, but did not occur in the course of employment because Applicant created his own “special mission that his employer did not request, demand or condone in some reasonably direct manner.” However, the Court found no evidence in the record that Applicant’s actions were beyond the scope of activities contemplated by his employment. In fact, it was clear that if

Applicant had asked a supervisor for permission to take his horse to the class to be shod, his request would have been approved. Therefore, the Court concluded that Applicant's injuries were sustained during a special mission benefiting the employer and thus arose out of and in the course of his employment. The Appeals Board's order was annulled and the matter remanded for further proceedings consistent with the Court's opinion.

C. Post-Termination Exclusion

Cross-reference

United States Fire Insurance Company v. WCAB (Urzua) – Apportionment/
Labor Code §4664

Arciga v. WCAB (2007) 72 CCC 1, Court of Appeal, Second Appellate
District, Division Six, unpublished opinion.

Applicant had been hired and laid off by the employer as a seasonal worker for 5 years. She and other workers were assigned the task of pruning grapevines for the first time. The workers were told that if they failed to meet daily production quotas, they would be laid off. Applicant's hands began to hurt and on the fourth day she complained to the foreman who gave her tape to wrap her hands. She also told the vineyard manager she could not sleep because of pain in her hands. She continued working. Four days later she and most of the other workers were terminated for failing to meet the quota. She was given a layoff notice which she signed, but did not read, believing it was just a prerequisite for obtaining unemployment benefits. The notice stated she had suffered no work-related injuries. Two days later, Applicant consulted her family doctor and a week later went to California Rural Legal Assistance where she was given a "WC application" to take to the employer. The human resources manager sent her to the industrial clinic where she was treated for bilateral hand tendonitis.

The WCJ found Applicant's claim was barred because she filed it after she was terminated in violation of Labor Code §3600(a)(10). Applicant filed a Petition for Reconsideration, contending that she did not know she had suffered a cumulative trauma injury at work, and that the employer was on notice of her work injuries as a result of her complaints about her hands prior to the termination. The WCJ recommended denial of the petition stating that complaints about aches and pains from "hard and heavy work" do not constitute notice of an industrial injury sufficient to trigger the duty to provide workers' compensation benefits. The Appeals Board adopted and incorporated the WCJ's report and recommendation, and denied reconsideration. Applicant sought judicial review.

The Court first stated that §3600(a)(10) does not bar the claim if the employer has notice of the injury prior to the notice of termination or layoff. The fact that Applicant told her supervisors that her hands were so painful and blistered she could not sleep convinced the Court that she had effectively reported the injury while she was still working, even though she may not have articulated her injury as "work-related" or "disabling."

The Court also pointed out that the date of a cumulative trauma, per §5412, “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.” Both of Applicant’s supervisors testified they did not know what a cumulative trauma was. Therefore, the Court reasoned, it would be unreasonable to expect that Applicant, a farm worker with a limited education, would understand the concept of cumulative trauma.

Finding that the conclusions reached by the Board “do not appear to comport with case law concerning cumulative injuries and the solicitude to be accorded workers like Applicant,” the Court remanded the matter with directions that the Board annul its decision and conduct further proceedings to determine whether Applicant sustained a cumulative trauma and whether the employer was on inquiry notice while she was working that she was suffering from work-related injuries.

Chavez v. WCAB (2007) 72 CCC 307, Court of Appeal, Fifth Appellate District, unpublished opinion.

The employer told Applicant that he was being laid off. A week later, he reported an injury and filled out a claim form concerning an injury that allegedly occurred earlier on the same day that he was notified of the layoff. The employer denied the claim based on the post-termination exclusion in Labor Code §3600(a)(10). The WCJ found that Applicant filed his claim after his termination and failed to prove he notified the employer of his injury before receiving notice of the layoff. The Appeals Board denied reconsideration.

Regarding Applicant’s claim that that he reported the injury before receiving notice of the layoff, the Court of Appeal stated that it was not permitted to reweigh the evidence or decide disputed questions of fact. Based on discrepancies in Applicant’s testimony and that of his witness, the WCJ could reasonably conclude he had not carried his burden of proof.

Applicant also argued that the employer must show prejudice in order for §3600(a)(10) to bar his claim because §5403 provides that lack of notice is not a defense unless the employer was misled or prejudiced. The Court pointed out that lack of notice is not the same thing as the post-termination exclusion. Here, Applicant did give notice of the injury within 30 days, as the statute requires, when he filed the claim form. Moreover, there is no statutory requirement that an employer must show prejudice in order for the post-termination exclusion to apply. Therefore, the Petition for Writ of Review was denied.

D. Psychiatric Injuries

Verga v. WCAB (2008) 73 CCC _____, Court of Appeal, Third Appellate District, published opinion. (Filed January 23, 2008)

Applicant alleged that she sustained a psychiatric injury as a result of harassment and persecution by her supervisor and co-workers. Applicant's QME found that the cause of her injury was negative interactions with her co-workers and her supervisor, based primarily on her description of the difficulties at work. According to Defendant's QME, Applicant's work conflicts were caused by her own inappropriate behavior and action; and substantially by good faith personnel actions. Thus, he believed that Applicant did "not meet the criteria necessary for an industrial etiology."

Applicant testified at trial as did a number of defense witnesses. The WCJ found that Applicant's testimony was not as credible as that of the other employees, and concluded that false perceptions of the working environment do not constitute actual events of employment. Therefore, Applicant failed to establish that "actual events of employment" were the predominant cause of her injury within the meaning of Labor Code § 3208.3. Applicant's Petition for Reconsideration was denied by a panel of Commissioners that adopted and incorporated the report of the WCJ. Applicant then sought judicial review which was granted.

The Court of Appeal noted that the legislative purpose of § 3208.3 had been to overrule the holding in *Albertson's v. WCAB (Bradley)* that an honest misperception of job stress, albeit a mistaken one, was sufficient to establish industrial causation. The enactment of § 3208.3 required the employee to establish "objective evidence of harassment, persecution, or other basis for the alleged psychiatric injury." In arguing that she should get workers' compensation benefits for work-related stress because she *perceived* her fellow employees' *disdain* as unusually stressful, Applicant was attempting to resurrect the subjective standard of *Albertson's*.

Applicant additionally contended that the Appeals Board's decision served to inject fault into a no-fault system. However, the Court noted that California's no-fault workers' compensation system is intended to permit recovery when an employee's own *negligence* caused his or her injury. It does not prohibit the Legislature from eliminating awards based on the employee's willful wrongdoing or misconduct.

The Court ultimately agreed with Appeals Board, finding that substantial evidence supported the findings that Applicant's supervisor and co-workers did not persecute or harass her. Rather, it was Applicant who caused the conflict and then misperceived as harassment her co-workers' disdainful response to her mistreatment of them. The disdainful reactions of co-workers to Applicant's abusive conduct was neither "actual events of employment" nor the "predominant cause" of her psychological injuries within the meaning of Labor Code § 3208.3. Thus, the Appeals Board's order denying compensation was affirmed.

California Insurance Guarantee Association v. WCAB (Tejera) (2007) 72 CCC 482, Court of Appeal, Second Appellate District, Division Six, writ denied

Applicant sustained orthopedic injuries and also claimed a psychiatric injury that Defendant denied on the ground that he had been employed for less than six months. At trial, Applicant credibly testified that he had been driving a truck and trailer on the date of injury, that he lost control of his truck and trailer on the wet highway, that the trailer jack-knifed, striking the cab of the vehicle numerous times, that he was thrown to the passenger side of the truck and then out the passenger side door, that the vehicle's steering wheel came loose in his hands, that he saw the trailer coming toward him as he lay on the ground and pavement, and that the trailer almost ran over his feet.

The WCJ found Applicant's psychiatric injury compensable under the "sudden and extraordinary employment condition" exception in Labor Code §3208.3(d). Defendant petitioned for reconsideration. In his report and recommendation, the WCJ acknowledged that that motor vehicle accidents generally were not extraordinary events, However, the circumstances of Applicant's accident were sufficient to be interpreted as "extraordinary" in that what happened to Applicant was not "frequent, regular or routine."

The Appeals Board denied reconsideration, adopting and incorporation the WCJ's report. Defendant's Petition for Writ of Review was denied.

Puga v. WCAB (2007) 72 CCC 175, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant's job duties required her to climb up and down a ladder several times a day. After working for the employer for two months, she injured her neck and spine in a fall from a ladder. The injury also resulted in a conversion disorder that rendered her permanently totally disabled. Defendant denied liability for the psychiatric injury on the ground that she had been employed for less than six months. The WCJ agreed and awarded 2 percent permanent disability for the spinal injury. Applicant petitioned for reconsideration, contending that her psychological injury was compensable because it was caused by a sudden and extraordinary employment condition. The panel affirmed the WCJ in a split decision with one Commissioner dissenting. Applicant sought judicial review.

The Court of Appeal distinguished the circumstances of Applicant's injury from the facts in *Matea v. WCAB* on the ground that she was engaging in her regular and routine employment activities at the time of her injury. Therefore, the Court concluded that her psychological condition did not arise out of an "extraordinary employment condition" as a matter of law.

V. Evidence; Presumptions**A. Evidence**

Mohammed v. Exxon-Mobil Corporation (2007) 35 CWCR 59, Appeals Board panel decision.

Two days before a scheduled MSC, Applicant's attorney requested a continuance to attend his son's graduation. When his request was denied, the attorney arranged for a hearing representative to appear. The representative neglected to submit a list of proposed exhibits and witnesses. At the trial, the WCJ admitted the reports of Applicant's QME, which had been served on defendant a year and a half before, and permitted Applicant to testify. The WCJ found in Applicant's favor. Defendant petitioned for reconsideration, contending that the WCJ should not have relied upon the reports of Applicant's QME and Applicant's testimony because evidence not disclosed at the MSC is inadmissible.

In her report and recommendation, the WCJ stated that the evidence in question was properly admitted in furtherance of her duty to develop the record, and that an applicant "may be implicitly assumed to be a witness in his [or her] own behalf." The Appeals Board added that there was no violation of Labor Code §5502 because Defendant was in possession of copies prior to the MSC and the reports had been reviewed by Defendant's QME. Furthermore, there was no indication that Defendant had been in any way prejudiced by the failure to list the reports in the MSC statement. In closing, the Appeals Board cautioned Defendant that this type of gamesmanship could lead to sanctions.

Cross-reference

George Reed, Inc. v. WCAB (Falkner) – Permanent Disability

B. Presumptions

California Horse Racing Board v. WCAB (Snezek) (2007) 72 CCC 903, Court of Appeal, Third Appellate District, published opinion.

Applicant was employed by the CHRB as a special investigator. He investigated violations of laws and regulations at the racetrack and, on occasion, arrested or detained suspected criminals. While at home, he suffered a heart attack. Applicant's doctor believed that work-related stress made a "medically significant" contribution to Applicant's heart condition. Defendant's QME found no permanent disability and that the heart attack was the result of obesity, smoking, hypertension, genetics, and physical deconditioning, and would have occurred regardless of his employment.

The WCJ ruled that Applicant qualified for the heart trouble presumption under Labor Code §3212, reasoning that Applicant had duties equivalent to a police officer for a political subdivision, by virtue of being in active law enforcement, making arrests, and enforcing sections of the Penal Code and other laws and regulations. Defendant filed a

Petition for Reconsideration which the Appeals Board denied, adopting and incorporating the report of the WCJ.

Defendant filed a Petition for Writ of Review contending that the WCJ erred in applying the heart trouble presumption for two reasons: First, even if the WCJ was correct that Snezek qualified as a police officer of a political subdivision, the only presumption that applies to that class of employees is the hernia presumption, not the heart trouble presumption. Second, Applicant was not a “police officer” of a political subdivision.

The Court noted that §3212 describes two types of employees that the Court called Class One and Class Two. The first group includes police officers of political subdivisions. The second consists solely of members of forestry and fire departments, active firefighting members of the Department of Forestry and Fire Protection, and members of the warden service of the Wildlife Protection Branch of the Department of Fish and Game.

A common sense reading of the language of §3212 led the Court to conclude to that the heart trouble presumption does not apply to police officers of political subdivisions. As employees in Class One, they are granted a hernia presumption, but only members of Class Two are accorded a heart trouble presumption, and there was no doubt that Applicant was not a Class Two employee. Thus, even if Applicant were deemed to be a police officer of a political subdivision, the WCJ erred in applying the heart trouble presumption to his case and it was unnecessary to reach Defendant’s second contention. The matter was remanded to the Appeals Board to determine whether Applicant’s heart condition was work related, without the benefit of the presumption.

Muna v. WCAB (2007) 72 CCC 1219, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant received a permanent disability Award for a prior specific injury. Subsequently, he filed a cumulative trauma claim against a subsequent employer. The defendant did not deny liability within 90 days of the filing of the claim form. The matter came on calendar for an MSC and the parties entered into the following stipulation on the record:

“Parties agree: Applicant sustained an admitted CT [cumulative trauma injury] 11/24/02, per LC § 5402. Defendants reserve the right to rebut based on later evidence.”

Defendant obtained an opinion from a QME that Applicant’s disability arose entirely out of the prior specific injury. Thereafter, Applicant selected a QME who expressed the opinion that 100 percent was caused as the direct result of his prior industrial injury and 0 percent was caused by factors other than his industrial injuries. Applicant deposed his own QME who reiterated that he did not believe Applicant sustained any additional disability as a result of cumulative trauma.

The WCJ found the injury to be compensable on the basis of the Labor Code §5402 presumption. However, on reconsideration, the Appeals Board reversed, concluding the

“presumption is properly rebutted when applicant’s own evidence proves that applicant’s injury is not compensable.” Applicant then sought judicial review.

Applicant first argued that the Appeals Board improperly amended the stipulation that the parties entered into at the MSC. The Court of Appeal expressed confusion over the basis for this contention, noting that Applicant did not specify “how the WCAB amended the stipulation and whether he alleges legal error by the WCAB or regret on his part for adopting the stipulation.” However, it found that the Board followed the stipulation as contemplated by the parties by presuming the injury to be compensable, but finding the presumption rebutted by later discovered evidence.

Secondly, Applicant claimed that Defendant failed to meet its burden of proof, that he did not sustain an industrial injury. Since Applicant had never presented any evidence that he sustained an injury and both evaluating physicians found that his disability was unrelated to his most recent employment, Defendant had met its burden of proof in rebutting the presumption of compensability. Therefore, the Petition for Writ of Review was denied.

Leprino Foods v. WCAB (Owens) (2007) 72 CCC 605, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant became involved in a series of altercations with a co-employee who drove a forklift toward him, causing him to jump and fall to the ground. Shortly, thereafter, while filling out a report of the incident, he asked his supervisor if he needed to fill out a form for the injury. The supervisor directed him to another person who was not in. The following day, Applicant was contacted by the company’s human resources manager. He again asked for a form to report the injury, but was advised he was being suspended and to take care of it when he returned to work. When he returned, he was terminated. Neither of the supervisors who terminated him responded to his request to report the injury. Six days later, applicant filed claim forms for both the forklift incident and a cumulative trauma. Additionally, he claimed the employer discriminated against him in violation of Labor Code 132a.

The matters came on for trial. The parties stipulated that Applicant was claiming “injury on a continuous trauma basis through 11/10/04 and a specific injury on 11/10/04.” The WCJ found both injuries to be compensable, with the date of the cumulative trauma on “either November 18, 2004 and December 14, 2004,” awarded temporary disability from December 14, 2004 subject to the lien of Employment Development Department, and found a need for further medical treatment. She also found that the employer violated Labor Code §132a. Defendant petitioned for reconsideration and the Appeals Board reversed the finding of employer discrimination, but otherwise adopted and incorporated the WCJ’s report and recommendation.

Defendant petitioned for judicial review concerning four issues. In the first place, it argued that it was improper for the WCJ to raise the Labor Code §5402 presumption *sua sponte* when it had not been mentioned in the pre-trial stipulations and issues. However, the Court noted that a presumption is an assumption of fact that the law *requires* to be

made from another fact or group of facts found or otherwise established in the action, and therefore may be considered at any time.

Defendant also complained that in light of the stipulation to the claimed ending date of the cumulative trauma, it was improper for the WCJ to find a different date of injury under Labor Code §5412. The Court rejected this argument, commenting that under Defendant's reasoning, if the evidence reveals that an injury occurred on any day other than that specifically alleged by an applicant, the Appeals Board would be powerless to issue a finding except one that exactly conforms with the allegation.

Defendant also claimed that the cases should have been barred by the post-termination exclusion since the claim forms were not filed until after the termination. However, the WCJ found that the date of injury was after the termination and Defendant never demonstrated that Applicant knew that his pain was causally connected to his injury until after the termination.

Error was also claimed in the finding of temporary disability which was based on the opinion of a doctor who evaluated on behalf of EDD on December 16, 2004 and another doctor who prepared a comprehensive orthopedic evaluation on June 1, 2005. In this regard, the Court merely commented that Defendant did not demonstrate that the Board's determination lacked substantial evidence. The Petition for Writ of Review was therefore denied.

DuFour v. WCAB (2007) 72 CCC 1081, Court of Appeal, Fifth Appellate District, unpublished opinion.

The deceased employee, a police officer, passed away in his home after having experienced two days of flu-like symptoms. His widow filed a death claim based on the Labor Code §3212.8 presumption linking blood-borne infectious disease and police employment. The matter came on for trial and was submitted for decision on the medical record. A doctor reporting for the County Coroner concluded that the employee passed away from an "undetermined natural disease" and a coroner from the different county concurred. Defendant's QME believed that given the flu symptoms, his death most likely was from an infectious origin. Applicant's QME admitted there was no evidence of a blood-borne pathogen in the employee's blood sample, but felt the presumption applied.

The WCJ found that the presumption didn't apply and that the death was not industrial. The Appeals Board affirmed and Applicant then sought judicial review. The Court of Appeal stated that Applicant never established the underlying basic facts necessary to invoke the application of the §3212.8 presumption, namely that a blood-borne infectious disease developed or manifested itself while the employee was working as a police officer. The Court further noted that it was inclined to agree with the Appeals Board that the Legislature intended the presumption to apply only to diseases that are transmitted via contact with blood, such as Hepatitis and AIDS, rather than so broadly as to include any organism that can travel within the bloodstream of its host. Therefore, the Petition for Writ of Review was denied.

IMC Chemical, Inc. v. WCAB (Smith) (2007) 72 CCC 591, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant filed a claim for workers' compensation benefits alleging skin cancer, lung cancer, and other internal injury to his entire body due to exposure to known carcinogens during the 15 years that he worked for the employer. Defendant admitted that he suffered from work-related atopic dermatitis, a relatively mild chronic skin disease, but denied that his employment led to any additional injuries. The matter proceeded to trial where Applicant was the only witness. The WCJ found the opinions of Applicant's doctors to be the most "complete and persuasive." He therefore found injury to all claimed body parts, awarded ongoing temporary disability and further medical treatment, and ordered the parties to develop the medical record on the issue of permanent disability.

Defendant petitioned for reconsideration, contending that Applicant failed to meet his burden of proof on all disputed issues. The Appeals Board denied the petition, adopting and incorporating the report of the WCJ. Defendant then filed a Petition for Writ of Review containing what the Court of Appeal described as "an extensive attack on the merits" of the Appeals Board's decision.

Defendant's contentions that the WCJ found the record to be less than adequate and that Defendant's medical experts were of a higher caliber than those selected by Applicant were dismissed by the Court as either untrue or irrelevant. Defendant also claimed that Applicant never entered into the record a list of chemicals to which he may have been exposed. However, Applicant did present a list of chemicals to his doctors and defendant never asked him to produce a copy of the list. More to the point, Defendant never refuted Applicant's claims of chemical exposure and never introduced evidence of what chemicals may or may not have been present at the facility during Applicant's employment.

The Court denied the writ and found that Defendant was liable for reasonable attorney fees under Labor Code §5801.

VI. Res Judicata/Collateral Estoppel

VII. Discovery

VIII. Earnings/Compensation Rate

County of San Joaquin v. WCAB (Davis) (2007) 72 CCC 187, Court of Appeal, Third Appellate District.

Applicant was an attorney employed by the State Fund, earning a monthly salary of \$7,299. He was called for jury duty for which he was paid \$5.00 per day by Defendant county. On his first and only day on jury duty, he sustained a back injury. He continued working for SCIF and ultimately underwent surgery. He filed Applications for

Adjudication against the County for the specific injury and against SCIF for a subsequent cumulative trauma. The WCJ found that Applicant was entitled to have his average weekly earnings calculated on the basis of his SCIF employment and on reconsideration, the Appeals Board affirmed. Defendant sought judicial review, contending that Applicant was only entitled to the minimum indemnity rated based on the \$5.00 per day that he earned while serving on jury duty.

The Court of Appeal noted that that *earning capacity* remains the benchmark for determining *average weekly earnings*, citing Labor Code §4453(c)(4) which provides as follows:

“Where the employment is for less than 30 hours per week, or where for any reason the foregoing methods of arriving at the average weekly earnings cannot reasonably and fairly be applied, the average weekly earnings shall be taken at 100 percent of the sum which reasonably represents the average weekly earning capacity of the injured employee at the time of his or her injury, due consideration being given to his or her actual earnings from all sources and employments.”

The Court held that there was no reason to believe that the application of this subdivision was limited to single employment cases. Here, Applicant was compelled to work for the County for a brief period of time and at a very low wage, an amount that clearly did not reflect his earning capacity before or after his injury. Thus, the Appeals Board’s decision was affirmed and Applicant was allowed to recover costs.

IX. Temporary Disability

A. In General

Sarabi v. WCAB (2007) 72 CCC 778, Court of Appeal, First Appellate District, Division Two, published opinion.

Applicant received an Award of total temporary disability, together with further medical treatment, for his 1999 injury. He underwent surgery in 2002 and later that same year filed a Petition to Reopen, alleging that a change in his condition resulted in further periods of temporary disability. An AME reported in 2004 that Applicant was TTD and needed further surgery. The surgery was postponed several times because he needed to be treated for a non-industrial condition before he could be medically cleared for surgery. The AME finally issued a supplemental report stating that if Applicant could not be medically cleared for surgery, he could be considered permanent and stationary a year after his initial report.

Prior to the AME’s supplemental report, Defendant had been voluntarily providing Applicant with TTD benefits since the date of the original Award. However, after receiving the report, it informed Applicant that payments were ending and that credit would be claimed for an overpayment of TTD. The matter came on for trial on the issue of whether Applicant was entitled to additional TTD benefits after the date that

Defendant terminated its voluntary payment of TTD based on the AME's supplemental report.

The WCJ awarded the additional TTD on an ongoing basis, finding that there was jurisdiction to issue the Award even if the additional TTD arose more than five years after the date of injury, because Applicant had filed a timely petition to reopen. Defendant petitioned for reconsideration claiming there was no jurisdiction to award TTD benefits because Applicant's Petition to Reopen was "skeletal" and because "jurisdiction was lost when the applicant was found to be permanent and stationary by the [AME]." Applicant responded that Defendant was estopped from objecting to the Petition to Reopen, having voluntarily paid TTD benefits and having never questioned his TTD status before that date.

In a split decision, the Appeals Board granted the Petition for Reconsideration, with the majority holding that although TTD may have been supported by the AME's initial opinion that surgery was necessary, there was no jurisdiction to award, as the WCJ did, TTD benefits more than five years after the date of injury. The dissent stated that since the AME initially found that Applicant was TTD and needed surgery, and since there was no evidence that he stopped needing the surgery, there was continuing jurisdiction to award TTD benefits. Applicant filed a timely Petition for Writ of Review, which the Court of Appeal granted.

The Court rejected Defendant's argument that the Petition to Reopen was defective since it was "skeletal," noting that the Supreme Court has held that very broad or general petitions are sufficient. Since Applicant's Petition to Reopen cited Labor Code §§5410 and 5803, alleged a change in his condition, and requested further temporary disability benefits, the petition was sufficient to inform Defendant of the nature of the claim and to confer jurisdiction on the Board to adjudicate the issues. Thus, the Board had continuing jurisdiction to render a decision in the matter after the five-year limitations period had expired.

Regarding Defendant's other contention, the Court stated:

"For an applicant to recover additional temporary disability benefits, he or she must not only have filed a petition to reopen within five years from the date of injury, but must also have suffered a "new and further disability" within that five-year period, unless there is otherwise "good cause" to reopen the prior award. (*citation*) An injured worker therefore cannot confer jurisdiction on the Board by filing a petition to reopen an award before the five-year period has expired for anticipated new and further disability to occur thereafter." (*citations*)

Nonetheless, even before the AME's initial report, Applicant's treating physician had been recommending surgery for some time. Both reports pre-dated the expiration of the five-year jurisdictional period. Because Applicant's disability worsened and further medical treatment in the form of surgery became necessary within the five-year period, Applicant suffered "new and further disability" within the meaning of §5410 and the Board had jurisdiction to award him additional TTD benefits.

The only reason that the WCJ's Award of TTD commenced after the five year period had expired was that prior to that date, Defendant had been voluntarily paying TTD and nothing prior to that date was in issue. The Court therefore made the following observation:

“To deny TTD benefits on the facts of this case would permit an employer, knowing that an applicant has filed a timely petition to reopen and has suffered a new and further disability within the pertinent five-year period, to make voluntary payments until after the five-year period has elapsed, so that any award for additional benefits would be jurisdictionally barred as commencing more than five years after the date of injury. This would be an unjust result and would conflict with the longstanding rule that “[l]imitations provisions in workmen’s compensation law must be liberally construed in favor of the employee unless otherwise compelled by the language of the statute, and such enactment should not be interpreted in a manner which will result in’ a loss of compensation.”

The Board’s order was annulled and the case remanded for a new order consistent with the Court’s opinion.

Agredano v. WCAB (2007) 72 CCC 381, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant injured her right hand and was awarded 46 percent permanent disability and medical treatment. She reopened her case for new and further disability and claimed to be suffering from depression arising out of the hand injury. Defendant resumed temporary disability payments and Applicant underwent several surgical procedures. Her treating physician recommended an additional surgery, but a month and a half later, reported that Applicant was not a surgical candidate due to anxiety and other psychological symptoms. Two and a half years later, her treating psychiatrist had not yet cleared her for further surgery. Accordingly, the PTP deemed her hand condition to be permanent and stationary unless she sufficiently recovered from depression and underwent additional surgery “in the near future.”

The matter came on for trial and the WCJ ultimately determined that Applicant was not entitled to further temporary disability. Applicant filed a Petition for Reconsideration and the panel adopted and incorporated the WCJ’s report. Applicant then sought judicial review.

Applicant contended that her right to procedural due process was violated because the Appeals Board determined she was not actively pursuing a claim of psychological injury and therefore did not consider evidence regarding the issue. However, the Court noted that only temporary disability was raised as an issue at trial and the psychological treatment was being provided for the orthopedic injury.

She further argued that the Board exceeded its authority by determining her permanent and stationary status at an expedited hearing since this is not one of the issues that are appropriate for expedited hearings per Labor Code §5502. The Court rejected this

argument also, noting that the concepts of temporary disability and permanent and stationary status are not mutually exclusive.

Applicant claimed that the Board's failure to set the expedited trial and issue the decision within the time constraints of §5502 amounted to a denial of due process. The Court responded to this contention by pointing out that the delays did not result in a delay or deprivation of benefits, nor did they affect the outcome. The Court also found that the Board's finding was supported by substantial medical evidence both in the form of the PTP's opinion and that of an AME who subsequently evaluated her and agreed with the PTP. The Petition for Writ of Review was therefore denied.

Cross-reference

Gomez (Vicente) v. WCAB – See Jurisdiction and Venue

City of Oakland v. WCAB (Aisthorpe & Watson) – See Special Benefits

B. Two Year TD Cap

Salmon v. WCAB (2007) 72 CCC 1042, First Appellate District, Division One, writ denied.

Defendant, a state agency, paid benefits at the industrial disability leave (IDL) rate for a year and thereafter for another year at the statutory temporary disability rate, terminating TD in reliance on the two-year cap in Labor Code §4656. The matter proceeded to trial on the issues of whether IDL was limited by the two year TD cap and if so, whether that limitation was unconstitutional. The WCJ found that Defendant was not liable for additional TD benefits since IDL benefits were the same as TD for the purpose of applying §4656, and the Board lacked the authority to declare a statute to be unconstitutional.

Applicant petitioned for reconsideration and the Appeals Board denied his petition, adopting and incorporating the report of the WCJ. Applicant's Petition for Writ of Review was denied.

Hawkins v. Amberwood Products (2007) 72 CCC 807, Appeals Board en banc opinion.

Applicant sustained a cumulative trauma ending July 16, 2004. Defendant paid TD for the period July 17, 2004 to July 14, 2006. However, it issued the initial TD check on May 3, 2005. Applicant claimed that the "104 compensable weeks within a period of two years from the date of commencement of temporary disability payment" started to run on the date that TD was first paid. Defendant claimed that the 2 year cap should begin on the date that TD was first owed. The WCJ agreed with Applicant based on the plain language of Labor Code §4656(c)(1). Defendant petitioned for reconsideration.

In an en banc decision, the Appeals Board affirmed the WCJ, holding that “that ‘the date of commencement of temporary disability payment’ as used in section 4656(c)(1) means the date on which temporary disability indemnity is first *paid*, and not the date for which temporary disability indemnity is first owed.” After noting that the language of the statute is clear and unambiguous, the Board further commented that this interpretation would provide a strong inducement to employers to promptly commence the payment of TD since the employer controls when the limitation on TD benefits begins to run. Moreover, there is no conflict with the statute’s reference to “aggregate” payments of TD because the payments do not begin to “aggregate” until they actually commence.

In a dissenting opinion, Commissioner Brass agreed with the defendant’s interpretation. He found the phrase, “date of commencement of temporary disability payment” to be ambiguous and felt that the majority’s holding would penalize employers who timely investigated the claim in good faith. He further observed that the Labor Code §4656(c)(2) provides for a higher cap of 240 compensable weeks within 5 years of the date of injury. Since the Legislature clearly intended to provide greater compensation for injured workers who suffered from those conditions, this purpose would be defeated if an injured worker who did not suffer from one of the listed conditions were potentially eligible to far more than 240 weeks of TD. In a footnote, he commented, in part:

“...However, I am troubled by the draconian swing from unlimited temporary total disability indemnity to the new limit of 104 weeks within two years. The anticipated savings in establishing this limit will result from the termination of payments to those injured workers who are most in need of it because of extended periods of temporary disability...”

Note: On October 15, 2007, the Governor signed Assembly Bill 338 into law. This bill amended Labor Code §4656 to allow the payment of 104 weeks of temporary disability within 5 years of the date of injury. The amendment nullifies the *Hawkins* decision in that the 5 years runs from the date of injury, without regard for the date that the initial payment of temporary disability was made.

Cruz v. Mercedes-Benz of San Francisco (2007) 72 CCC 1281, Appeals Board en banc opinion.

In connection with an admitted injury, Applicant underwent extensive back surgery which included removal of bone from a vertebra and from his hip. He was not yet permanent and stationary when the carrier discontinued temporary disability benefits two years after the initial payment in accordance with Labor Code § 4656. The WCJ awarded additional temporary disability, reasoning that the removal of bone met the definition of an “amputation” which entitled Applicant to benefits beyond the two year/104 week cap.

Defendant petitioned for reconsideration arguing that the WCJ’s interpretation was overly broad; that applicant’s condition was not as severe as the enumerated exceptions in section 4656(c)(2); that the Legislature could have included spinal surgery in the exceptions, if it wished, but did not; and that, in any event, even liberal construction will

not extend temporary disability benefits where they are not authorized. Applicant responded that that the statute was ambiguous; that the legislative intent was indiscernible; and that it would therefore be necessary to utilize the “liberal construction rule” of Labor Code § 3202 to adopt an interpretation that was beneficial to injured workers.

The Appeals Board first noted that the only issue presented in this case was whether Applicant’s surgeries fell within the meaning of the term, “amputation,” which would entitle Applicant to the higher cap on temporary disability indemnity in Labor Code § 4656(c)(2)(C).

Turning to the merits, the Board commented that while a persuasive argument could be made that the Legislature intended to create exceptions for serious conditions, Labor Code § 4656 does not mention seriousness as a criterion and does not contain an additional subdivision for “other equally serious conditions.” Furthermore, the fact that the list of exceptions is susceptible to charges of both over-inclusiveness and under-inclusiveness, does not confer upon the Board the liberty to rewrite it or to use the guise of interpretation to amend the statute to the Board’s own tastes.

Since the reasonable definition of the term, “amputation” did not support the decision of the WCJ, the Appeals Board amended the F & A to find that Applicant’s spinal surgeries did not constitute an amputation and that Applicant was not entitled to additional temporary disability indemnity.

One Commissioner concurred with the majority in terms of the Appeals Board’s obligation to carry out the intent of the Legislature, but offered the following commentary:

“The purpose of temporary disability indemnity is to provide interim wage replacement assistance to an injured worker during the period he or she is healing.” [citation] In this case, applicant is not yet healed but is ineligible to receive indemnity payments because of the two-year/104-week cap. From this limitation, the Legislature has carved out exceptions for specified injuries or conditions, while leaving other equally devastating conditions, such as traumatic brain injuries or failed back syndrome, subject to the cap. There is no rational basis for this disparate treatment of equally serious injuries.

Gunzenhauser v. WCAB (2007) 72 CCC 1087, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant sustained a serious industrial injury in September 2004. He remained temporarily disabled two years later when defendant terminated temporary disability benefits in reliance of the two year cap in Labor Code §4656. Applicant requested an expedited hearing alleging that the two year cap on temporary disability was unconstitutional. The WCJ correctly noted that the law was clear and that trial level WCJ’s are not empowered to remedy alleged inequities in the law. On reconsideration, the Appeals Board affirmed. Applicant then filed a Petition for Writ of Review, urging the appellate court to find Labor Code §4656(c) to be unconstitutional.

The Court of Appeal first noted that in considering a constitutional challenge to a statute, the Court is guided by a general presumption of validity and uphold the provision unless it “plainly and unmistakably” conflicts with the California Constitution. It was Applicant’s contention that by limiting temporary disability indemnity payments to two years for his serious injuries, the Legislature violated the constitutional mandate to enact a complete system of workers’ compensation with “adequate provisions for the comfort, health and safety and general welfare of any and all workers” so as to accomplish “substantial justice.” (Cal. Const., art. XIV, § 4.)

Disagreeing with Applicant, the Court found no constitutional requirement to provide temporary disability payments for any specific period of time. Since Constitution provides that, “The Legislature is hereby expressly vested with plenary power, unlimited by any provision of this Constitution, to create, and enforce a complete system of workers’ compensation” (Cal. Const., art. XIV, § 4.), this plenary grant of authority permits the Legislature to enact, amend, and delete statutory workers’ compensations benefit provisions as it deems appropriate.

The Court also pointed out that after temporary disability benefits terminate in a serious case, the employee will then be eligible for permanent disability advances and ultimately a life pension for those injured workers whose permanent disability is 70 percent or above. Declining to “second guess the Legislature’s objective and design,” the Petition for Writ of Review was denied.

Medeiros v. WCAB (2007) 72 CCC 857, Court of Appeal, Sixth Appellate District, writ denied.

Applicant sustained an industrial back injury on April 19, 2004. He underwent back surgeries in November 2004 and June 2005. Defendant terminated payments of temporary disability in April 2006, two years after the initial payment pursuant to Labor Code § 4656©(1). Applicant claimed entitlement to additional temporary disability. At the trial, the parties stipulated that Applicant’s condition was not permanent and stationary and that he was a candidate for additional surgery.

The WCJ found that Applicant was not entitled to further temporary disability. Applicant filed a Petition for Reconsideration contending that (1) Labor Code § 4656(c)(1) is unconstitutional because it violates Applicant’s right to receive fair and adequate benefits; (2) the plain reading of Labor Code § 4656(c)(1) allows payment of TD indemnity beyond two years since the law limits only the number of weeks TD is payable in a two-year period rather than limiting benefits to 104 weeks total; and (3) Defendant should be equitably estopped from benefiting from the 104-week limit since it delayed providing medical care, including authorization for diagnostic care requested.

In her Report and Recommendation, the WCJ stated that she did not have the power to declare a statute unconstitutional. Regarding Applicant’s second argument, such an interpretation would render the reference to 104 weeks meaningless and suggest that the Legislature was only reciting the number of weeks in two years. There was no basis for

finding an equitable estoppel because Defendant did not attempt to induce any conduct on the part of Applicant based on a false premise. The Appeals Board denied reconsideration, adopting and incorporating the WCJ's report.

City of Oakland v. WCAB (Aisthorpe & Watson) (2007) 72 CCC 249, Court of Appeal, First Appellate District, Division One, writ denied.

Applicants, both police officers, were injured in an automobile accident. After a brief initial period of temporary disability during which time she was compensated, Applicant Aisthorpe returned to work for a year and then went off again to undergo surgery. Six months after the surgery, she returned to modified duty, working six hours per day and receiving two hours of Labor Code §4850 benefits until Defendant terminated the benefits two-years after the initial payment. Applicant Watson also returned to work after an initial period of temporary disability and became disabled again a year later. After the employer discontinued her benefits two years after the initial payment, she underwent back surgery.

The consolidated cases proceeded to an expedited hearing on the sole issue of whether the 104-week limitation for payment of total temporary disability set forth in Labor Code §4656 applies to benefits paid under Labor Code § 4850. The WCJ issued a decision in which she concluded that the new statutory limitation does not apply to payments made pursuant to Labor Code §4850. Defendant filed a Petition for Reconsideration, contending in relevant part that payments made under Labor Code §4850 are the equivalent of temporary disability payments.

The WCJ recommended that reconsideration be denied, rejecting Defendant's contention that §4850 benefits are equivalent to TD and pointing out that §4850 benefits are distinct and more expansive than TD paid pursuant to Labor Code §4656. She noted that in SB 899 the Legislature amended Labor Code §4656 to include the 104-week limitation on TD but did not make any change to Labor Code §4850. The Appeals Board denied reconsideration, adopting and incorporating the WCJ's report. Defendant filed a Petition for Writ of Review that was denied without an opinion.

X. Medical Treatment

A. In General

Target Stores v. WCAB (2008) 73 CCC _____, Court of Appeal, Fifth Appellate District, unpublished opinion. (Filed January 18, 2008)

Applicant sustained injury to her right elbow and wrist in 1991. She was evaluated by AMEs in neurology and orthopedics. Both doctors reported complaints of neck pain. In 1994, the parties entered into Stipulations With Request for Award in which it was stipulated that Applicant sustained injury to her "right elbow and arm" resulting in permanent disability based on the opinion of the orthopedic AME rated as follows:

18.1 (
25% - 38F - 25 + 24-1/2%
7.3 (

“There is a need for medical treatment per Doctor Chittenden.”

Defendant continued to pay for medical care related to Applicant’s right elbow, arm *and neck*. After 2002, Defendant advised Applicant’s treating physicians and counsel that it would no longer provide treatment pertaining to her neck because it was not listed as a part of body in the Stipulations and there was a possible overlap with two subsequent injuries that were resolved by C & R.

In 2005, Applicant filed a Petition to Reopen “pursuant to Labor Code Section 5803 to correct a clerical error.” The matter came on for trial in 2007 and the WCJ issued an amended F & A concluding that although the WCAB had lost jurisdiction to *reopen* the matter involving the 1991 injury, good cause existed to grant Applicant’s request to *enforce* the prior Award. Alternatively, the WCJ also found that a subsequent industrial injury resulted in only minor injury to her neck and Applicant likely would not have entered into a C & R with that employer had she not already been receiving medical care from Defendant; thus, Defendant was “estopped from denying injury to the neck at this point.”

The Appeals Board denied reconsideration and Defendant filed a Petition for Writ of Review, contending that the Appeals Board erred by awarding Applicant medical treatment for her neck 14 years after her industrial injury and 11 years after the WCJ approved the Stipulations With Request for Award. It also argued that the Board improperly considered its past payment for neck treatment an admission of liability.

The Court of Appeal noted that while the Board’s power to *alter* prior decisions is limited to five years from the date of injury under Labor Code §§ 5410 and 5804, its authority to *enforce* its awards is not time-barred. Looking to the substance of Applicant’s request, the WCJ properly deemed the filing a petition to enforce the prior Award. The WCJ and the Appeals Board did not construe Defendant’s payments for the neck injury an admission of liability, but rather, considered them to be relevant in interpreting the 1994 Stipulated Award which contained the reference to 18.1, the formula for the spine.

The Petition for Writ of Review was denied and the matter remanded to the Appeals Board to issue a Supplemental Award of reasonable attorney fees.

Save Mart v. WCAB (2008) 73 CCC _____, Court of Appeal, Fifth Appellate District, unpublished opinion. (Filed January 11, 2008)

Applicant injured her back in August 2002. She treated with Dr. Fujihara at the industrial clinic, but became dissatisfied and agreed to be seen by Dr. Allende who reported in September 2002 that she could return to work with no further need for treatment. Dr.

Allende did not examine Applicant; rather she was examined by his physician's assistant. Defendant discontinued TD benefits. A week later, Applicant re-injured her back. She was again seen by Dr. Fujihara who diagnosed an aggravation of the prior injury and recommended physical therapy and light duty work.

Now dissatisfied with both Dr. Fujihara and Dr. Allende, Applicant sought treatment with Dr. Schroeder, a chiropractor, three days later. She gave him a history of the September 2002 injury but also signed a form entitled, "Employee Request to Change Physician First 30 Days," listing the August 2002 injury. By letter, Defendant notified Applicant that she must either see a doctor affiliated with Dr. Allende's group or seek an evaluation from a QME regarding her September 2002 injury.

Applicant selected a chiropractic panel QME who found her to be permanent and stationary with a limitation to light work, and in need of further treatment. His opinion did not change after he viewed sub rosa films. Pursuant to an order from the WCJ, Applicant was then seen by Dr. Allende who concurred with the panel QME except that he did not believe chiropractic treatment would be of value. She continued to treat with Dr. Schroeder who ultimately declared her condition to be permanent and stationary, and filed a lien for his treatment which defendant refused to pay.

Defendant deposed both Applicant and Dr. Allende who changed his opinion after viewing the sub rosa films, reducing the work restrictions, but still recommending further treatment. Based on Dr. Allende's opinion that the surveillance films were inconsistent with the history Applicant provided, she was charged with two felony counts of workers' compensation fraud and one felony count of attempted perjury. Applicant pled no contest to a single misdemeanor count of making a false or fraudulent material statement at her deposition and paid a fine.

The matter came on for trial and the WCJ made various findings regarding the designation of the physicians and their right to treat Applicant, the effect of her no contest plea, her entitlement to temporary disability, and attorney fees. Regarding permanent disability, further development of the record was required. Defendant's Petition for Reconsideration was denied and it then sought judicial review.

Defendant contended that Applicant could not select Dr. Schroeder as her PTP within 30 days of her initial August 2002 injury because she already selected Dr. Allende who found that she no longer required medical treatment. However, The Court pointed out that since Dr. Allende did not personally examine Applicant in September 2002, his report was inadmissible before the WCAB and could not be relied upon. Defendant's argument that Dr. Schroeder could not serve as the PTP for Applicant's second injury in September 2002, because she had already been discharged by Dr. Allende was found to be without merit for the same reason, and was further refuted by the prior reporting of Defendant's own Dr. Fujihara. Defendant's claim that Applicant was not entitled to TD based on Dr. Schroeder's reports was rejected for the same reasons.

Defendant also disputed Applicant's right to receive TD as a result of her no contest plea. After reviewing the factors set forth in *Tensfeldt v. WCAB* (1998) 63 CCC 973, the Court concluded that Applicant remained entitled to recover workers' compensation benefits because her injuries were admitted by defendant; the medical reporting from Dr. Schroeder and the panel QME independently substantiated the need for TD and medical treatment; and the WCJ did not find that her misdemeanor plea so destroyed her credibility as to make her unbelievable.

Noting that Defendant was "[a]pparently of the opinion an argument becomes more convincing the more often it is repeated and rephrased," the Court rejected additional contentions based on Defendant's insistence that Dr. Allende was the PTP, and that the reports of Dr. Schroeder and the panel QME did not constitute substantial evidence. Thus, defendant was properly made liable for the cost of Dr. Schroeder's treatment. Since Defendant filed an Application for Adjudication when Applicant was unrepresented, it was liable for attorney fees pursuant to Labor Code § 4064. Lastly, Defendant's failure to raise the issue of the EDD lien before the Appeals Board on reconsideration constituted a waiver.

In denying the Petition for Writ of Review, the Court found no reasonable basis for the petition and remanded the matter to the Appeals Board to make a Supplemental Award of reasonable attorney fees.

Little v. WCAB (2007) 72 CCC 1498, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant litigated the issue of whether his medical treatment Award included treatment for hypertension and erectile dysfunction. The WCJ found that his industrial injuries aggravated his hypertension, but did not cause any erectile dysfunction disorder. Applicant petitioned for reconsideration and the WCJ vacated the decision and later reissued it. When he petitioned a second time, the decision was again vacated and reissued. Applicant filed a third petition, essentially stating his disagreement with the decision and referring to his prior petitions for further details. This time, the WCJ did not vacate the decision, but recommended further development of the record.

The Appeals Board majority first denied the petition as skeletal, noting the lack of statutory grounds or reference to the record. It then went on to note, that even if the petition were not skeletal it would be denied on the merits because Applicant did not meet his burden of proving industrial causation. The dissenting Commissioner would have returned the matter to the WCJ to further develop the record. Applicant sought judicial review.

The Court of Appeal addressed the merits, noting that neither QME found any medical basis for Applicant's claim. The defense QME concluded that back pain does not cause sexual dysfunction, and while Applicant's QME concluded the back pain may "negatively influence erectile dysfunction," he believed the underlying pain should be

treated orthopedically rather than providing Viagra on an industrial basis. Thus, the Petition for Writ of Review was denied.

In a footnote, the Court shared the panel's "discontent with counsel who could not, at the very least, cut and paste the same discussion into the new petition," commenting that "[a]sking a tribunal to search its own files if it 'should be so inclined' for prior arguments and evidence in the record is no way to succeed in litigation."

Hodgeman v. WCAB (2007) 72 CCC 1202, Court of Appeal, Second Appellate District, Division One, published opinion.

Applicant sustained a catastrophic industrial injury that left him with severe cognitive and physical deficits, necessitating residence in an assisted living facility. His mother was appointed guardian ad litem. She and her husband were later appointed conservators of Applicant's person and estate by the superior court. Applicant's mother, who had no prior medical knowledge or training, undertook extensive self-study on closed brain injuries. She also participated in family support groups. She continued to do research as issues arose and acquired and conducted an in-depth study of all of her son's medical reports.

On the recommendation of Applicant's doctors, his mother's services included attending all medical appointments and medical team conferences, informing and interacting with all medical providers regarding medical and behavioral issues as they arose, evaluating and checking on the level of attendant care and medications, inspecting equipment and arranging for necessary repairs, maintaining and delivering supplies, and, because her son risked food aspiration, reviewing and adjusting his menus.

Applicant's mother took care to log separately the time she spent on medically related activities for which she sought compensation from the employer in the workers' compensation proceedings and nonmedically related activities for which she obtained compensation from the conservatorship in superior court. However, a dispute arose in regarding the question of whether she was entitled to be compensated, in her capacity as guardian for "medical treatment," such as nursing or housekeeping services, and for the extraordinary amount of time she devoted to ensuring that her son received appropriate medical care. Nine years later, she and the employer entered into a C & R regarding her claimed expenses to date. The following language was contained in the settlement:

"For the next six (6) months, it is agreed that the Guardian Ad Litem will be entitled to \$25.00 per hour for reasonable and necessary services, which shall not be duplicative* to other services. At the termination of the six (6) month period, the parties will re-negotiate the hourly amount. Six month period beginning upon submission of this document to WCAB. . . . [¶] *Duplicate services *shall not be interpreted as any two parties such as the legal guardians and the case manager attending to the same issue*, as it is often necessary for both parties to attend appointments jointly; to discuss medical & equipment issues, etc." (Italics added.)

Pursuant to the Order Approving C & R, the guardian submitted monthly statements to the employer which compensated her without objection for five years and then abruptly

stopped paying. She then filed a petition to enforce the C & R and obtain penalties and reasonable attorney fees. The employer responded that the C&R was limited to six months, with the hourly amount to be renegotiated, but there was no agreement that it was required to pay for any guardian ad litem time or expense, nor was there any case law or statutory law requiring such payments. The guardian argued that the C&R was res judicata.

The WCJ ruled that the C&R was res judicata, but only as to services that pre-dated the C & R. She further ruled that there were no additional services for which the guardian could be compensated under the C&R and that she should look to the Superior Court conservatorship for payment. Since Labor Code §5307.5 permits guardian ad litem fees to be compensated upon filing an account either with the Board or with the Superior Court, but not both, she concluded that the services for which the guardian was seeking reimbursement fell totally within the parameters of her conservatorship duties.

The guardian filed a Petition for Reconsideration. In her report and recommendation, the WCJ came to a decision that differed from her original opinion, stating that that

“...although [the guardian] “could very well be compensated for all the services she provides for her son relating to his personal needs, his financial needs, or his medical decision needs through the Superior Court, this would not preclude her from being reimbursed by the carrier for those medical services which would be allowable to her under Labor Code §4600, as long as she did not simultaneously claim reimbursement for them in her role as conservator.

She recommended to the Board that, because the C&R was ambiguous as to what continuing services were anticipated, that her original finding be amended to read:

“[Guardian ad litem] is entitled to be reimbursed for services rendered pursuant to Labor Code section 4600 and for which she does not receive compensation relative to her role as a Conservator, and for which services are not duplicative or capable of being duplicated by other professionals such as the LVN, to be paid by defendants [Community Care Center and its carrier] in amounts to be determined by the parties or by further development of the record and supplemental proceedings.”

The Board granted the Petition for Reconsideration, affirmed the WCJ’s decision, and amended the finding as recommended by the WCJ. Applicant sought judicial review, contending that the Board unreasonably impaired her right of compensation for attending to the medically necessary needs of her son because decisional law interpreting Labor Code §4600 encompasses care provided by a lay person which might have been done by a professional, including a licensed vocational nurse.

The Court agreed, noting that the care for which the guardian requested compensation from the employer did not fall under the duties of a conservator, but were equivalent to medical treatment and should be paid by the employer for the industrial injury Applicant suffered, not paid out of his funds in the conservatorship estate. When the guardian performs acts that may be considered medical care, the Board has jurisdiction to determine whether compensation is due, not as a conservator, but as a caregiver. The

Court directed the Board to leave it to the Superior Court to ensure that the guardian was not compensated for the same care in the conservatorship.

As for the C & R, the WCJ interpreted the C&R incorrectly. The C&R made it clear that the guardian's caregiving services were compensable even if they were duplicative of professional services such as those performed by the case manager. By its plain language, the C&R was renegotiable only with regard to the rate of pay, and the WCJ, in effect, rewrote the C&R to exclude duplicative services.

The Court also agreed with the guardian that she was entitled to a penalty assessment under Labor Code §5814 and attorney fees pursuant to Labor Code §5814.5 for efforts to obtain the penalty. The Appeals Board's decision was annulled and the matter remanded for further proceedings consistent with the Court's opinion.

County of Stanislaus v. WCAB (Credille) (2006) 71 CCC 1381, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant was awarded permanent disability of 1 percent after apportionment to pre-existing polio. She was also awarded further medical treatment. Defendant provided periodic adjustments to Applicant's leg braces for nine years after the Award was issued. Her treating physician then recommended that the leg braces be replaced which Defendant resisted based on the opinion of a QME. The WCJ concluded that Applicant was entitled to the leg braces on an industrial basis in accordance with the prior Award and on reconsideration, the Appeals Board adopted and incorporated the WCJ's opinion.

The Court of Appeal found that the Appeals Board's decision was supported by substantial evidence in that Applicant had an Award of medical treatment; the need for the braces was partially caused by the industrial injury; and medical treatment may not be apportioned. The Petition for Writ of Review was denied and the matter remanded to the WCAB to issue a Supplemental Award of attorney fees.

B. ACOEM Guidelines/Utilization Review

Sutton v. WCAB (2007) 72 CCC 1227, Court of Appeal, Fifth Appellate District, unpublished opinion.

In 1985, Applicant and Defendant entered into Stipulations With Request for Award in which it was provided at paragraph 4 that there "may be need" for medical treatment. Directly underneath was handwritten: "for the back and hip and right shoulder only, and upon reasonable demand." In 1996, the employer contested its liability to provide medical treatment and The WCJ ordered it to provide reasonable medical treatment on an ongoing basis based upon the original stipulations.

In 2006, Applicant requested an expedited hearing because Defendant refused to provide him with chiropractic services. At the trial, he testified that the chiropractic treatments allow him to function and work and that he "can't get by unless he has one or two

treatments a week if he's had a flare-up." He estimated he had about a dozen flare-ups over the past year. The WCJ issued an interim Award of continuing care with the treating chiropractor for six months and ordered the parties to "develop the medical record with respect to what is the best care that applicant can receive to cure and/or relieve from the effects of his injury."

Defendant filed a Petition for Reconsideration which was granted. Not finding any specific evidence in the record that Applicant required treatment falling within the ACOEM Guidelines, but agreeing with the WCJ that Applicant may be entitled to treatment not only to cure but also to relieve him from the effects of his injury, the Appeals Board rescinded the WCJ's interim Award and remanded the matter to further develop the medical record. Applicant then sought judicial review claiming that the 1985 Stipulated Award and the subsequent 1996 Order effectively mandate the employer to provide any chiropractic care Applicant seeks without oversight and that the treatment was not subject to the ACOEM Guidelines.

The Court of Appeal first noted that the Appeals Board's decision was not a final order and therefore not subject to judicial review. However, to the extent that the Board found that the ACOEM Guidelines were applicable to the current treatment, this was a final determination on a threshold issue that the Court could address. In denying the Court found that Labor Code §4604.5 "could not be more clear" in its mandate that the ACOEM Guidelines presumptively establish reasonable medical treatment, "regardless of the date of injury," subject to Applicant's right to rebut those standards with substantial medical evidence. The Court also addressed Defendant's argument that the chiropractic care was subject to a 24 visit cap by noting that the statute does not apply to pre-1994 dates of injury.

B. ACOEM Guidelines/Utilization Review

C. Medical Provider Networks

Babbitt v. WCAB (2007) 72 CCC 70, Fifth Appellate District, writ denied.

The Appeals Board issued an en banc opinion (*Babbitt v. Ow Jing dba National Market* (2007) 72 CCC 70) in which it held that an employer or insurer may satisfy its obligation to provide reasonable medical treatment under Labor Code §4600 through an authorized MPN; that an MPN may be used to provide reasonable medical care, regardless of the date of injury or the date of an award; and that an injured worker may be transferred to an authorized MPN for medical treatment in conformity with applicable statutes and regulations.

Applicant filed a Petition for Writ of Review which was denied without further comment.

Babbitt v. Ow Jing dba National Market (2007) 72 CCC 70, Appeals Board en banc opinion.

In 2003, Applicant's claim was resolved by Stipulated Award that included a provision for further medical treatment. In 2006, the matter came on calendar for an expedited hearing after Defendant sought to transfer Applicant's care to its MPN. The parties agreed that the MPN was properly certified and that Defendant had served all required notices. The sole issue presented was whether Applicant should be required to cease treating with her present physician and be ordered to select a physician within the MPN. The WCJ found that Defendant was entitled to compel treatment within the MPN. Applicant petitioned for reconsideration.

After reviewing the various statutory changes that occurred over the years in the rules for selecting a treating physician, the Appeals Board held that an employer or insurer may satisfy its obligation to provide reasonable medical treatment under Labor Code §4600 through an authorized MPN. Additionally, it held that an MPN may be used to provide reasonable medical care, regardless of the date of injury or the date of an award, because the Legislature's establishment of MPN's was a procedural rather than a substantive change in the law. Lastly, it held that an injured worker may be transferred to an authorized MPN for medical treatment in conformity with applicable statutes and regulations.

Applicant's argument that the insurer or employer must demonstrate that there has been a change of condition or defective or incomplete medical treatment before transferring an injured worker into an MPN was rejected on the basis that the MPN statutes do not give the Defendant complete control over the identity of a treating physician. Injured workers have the right to select a physician within the MPN and to obtain second and third opinions. Furthermore, the MPN statutes and regulations identify four specific situations where continued treatment with a designated outside physician is allowed for a period of time, and these exceptions would be rendered null and void by an additional requirement that the Defendant prove some type of default before transferring employees into an authorized MPN. Therefore, the decision of the WCJ was affirmed.

XI. Medical Evidence

A. Medical-Legal Procedure

Romero v. Costco Wholesale (2007) 72 CCC 824, Appeals Board Significant Panel Decision.

Before Applicant was represented by an attorney, her treating physician recommended physical therapy, including pool therapy. Defendant objected to the proposed treatment pursuant to Labor Code § 4062, and advised applicant in writing of the applicable procedure to resolve the dispute. When no response was received to the objection,

Defendant requested a panel from the DWC Medical Unit. The Medical Unit issued the panel four days after Applicant retained counsel.

When the parties were not successful in selecting an AME, defendant scheduled an appointment with the orthopedic surgeon it selected from the QME panel. In the meantime, Applicant designated a new treating physician, a chiropractor, and demanded a new panel from the Medical Unit, in the specialty of chiropractic. When the Medical Unit declined to grant her request, she petitioned the WCAB and the WCJ ordered the Medical Unit to issue a new panel, comprised of three chiropractors. Defendant then filed a petition for removal.

The Appeals Board panel noted that Labor Code 4062.1(e) provides as follows:

“If an employee has received a comprehensive medical-legal evaluation under this section, and he or she later becomes represented by an attorney, he or she shall not be entitled to an additional evaluation.”

In Applicant’s case, since she did not attend the evaluation with the panel QME, it could not be said that she “received a comprehensive medical-legal evaluation” under Labor Code § 4062.1. Therefore, she was not precluded from requesting a new QME panel pursuant to § 4062.2. The Appeals Board panel found that the WCJ did not err in ordering a new QME panel consisting of chiropractors and Defendant’s Petition for Removal was denied.

B. Spinal Surgery Second Opinion

Laing v. WCAB (2007) 72 CCC 767, Court of Appeal, First Appellate District, Division One, unpublished opinion.

Applicant sustained an industrial injury to his low back. His treating physician recommended surgery. Defendant objected to the procedure, and the parties selected an AME for a second opinion. Subsequently, Applicant withdrew from the AME agreement, but did attend the examination. The doctor recommended against surgery. The matter came on for trial and the WCJ awarded the surgery based on the opinions of three other doctors who recommended some type of surgical procedure.

Defendant’s Petition for Reconsideration was granted. The Appeals Board implicitly rejected Defendant’s argument that Applicant’s withdrawal from the AME agreement was nullified by his submission to the examination. However, it then went on to rely on the doctor’s opinion on the ground that the opinion was in compliance with the ACOEM Guidelines which are presumptively correct on the question of the scope of medical treatment.

Applicant sought judicial review, contending 1) that Defendant failed to timely object to the treating physician’s surgical recommendation and 2) that because he withdrew from

the AME agreement, the WCJ was required to implement the second opinion random selection procedures of Labor Code §4062(b).

The Court summarily rejected Applicant's argument that Defendant had failed to file a timely objection to the recommendation for surgery because the WCJ expressly found the objection to be timely, and the finding was supported by the record. In any event, the issue was waived by the failure to raise it on reconsideration. It likewise rejected Defendant's argument that the withdrawal from the AME agreement was nullified by Applicant's attendance since Defendant offered no legal authority to support its position.

However, it agreed with Applicant that the WCJ and the Board erred by failing to require the administrative director to randomly select a surgeon or neurosurgeon to render a second opinion. In addition, the Court found that the Board erred in applying the ACOEM Guidelines because Chapter 12 of the Guidelines only applies to conditions of three months duration or less and therefore, the evidentiary presumption never arose. The matter was remanded to the Appeals Board to issue a new decision after following the spinal surgery second opinion procedure outlined in Labor Code §4062(b).

Sacramento County Office of Education v. WCAB (Burnett) (2007) 72 CCC 954, Court of Appeal, Third Appellate District, unpublished opinion.

Applicant's secondary physician requested authorization to perform a discectomy for her industrial back injury. The employer withheld approval pending consultation with a second opinion doctor. The parties selected an agreed neurosurgeon and Applicant's attorney indicated in writing that Applicant would abide by the doctor's opinion. In April 2005, the agreed doctor recommended against the surgery, stating the outcome was likely to be poor given the length of time Applicant had had the condition and the inconsistencies between the test results and her complaints.

The secondary physician still maintained that Applicant needed surgery in light of the "failure of prolonged conservative treatment in relieving her symptoms." After a new MRI was performed in May 2005, he again requested authorization for the surgery. This information was forwarded to the agreed doctor who issued a supplemental report in July 2005 stating that he "could not fault [the secondary physician] if at this point in time he attempted to go in and take the disc out," but he would "question whether the patient's symptoms . . . and the objective findings on scans are all correlative in nature." Based on this report, Defendant refused to authorize the surgery.

Thereafter, Applicant's condition deteriorated. In October 2005, she obtained a new attorney and a new treating physician who again recommended surgery in December 2005 because conservative treatment had failed. In January 2006, Applicant underwent the surgery which was performed under her private medical insurance. The employer denied payment for the treatment or for temporary disability benefits. The employer also rejected Applicant's request that the agreed doctor review the need for the surgery after the fact, on the ground that there was no statutory basis for this.

The dispute came on calendar for a conference at which time Applicant asserted that the employer's failure to initiate Board proceedings to resolve the conflict of opinions rendered it liable for the costs of her surgery. The employer, on the other hand, noted that it would produce evidence from its attorney and Applicant's prior attorney that there was agreement between them to accept the second opinion as binding.

After a trial, the WCJ interpreted the July 2005 supplemental opinion as "reluctantly agree[ing] that the surgery was reasonable and necessary." He therefore ordered the employer to authorize the surgery without any need for another consultation, and awarded temporary disability effective September 2005. He did not address Applicant's contention regarding the employer's failure to initiate Board proceedings. After its Petition for Reconsideration was denied, Defendant sought judicial review.

Addressing the original contentions of the parties, the Court noted that there were a number of points in the record from which the Court could infer an agreement on Applicant's part to be bound by the opinion of the agreed doctor. Furthermore, she could not prevail on her contention that the defendant's failure to timely initiate Board proceedings entitled her to the surgery. Because the WCJ failed to make a finding on the issue after it had been raised, the Court was required to deem it to have been resolved against her. At that point, Applicant would have had to file a Petition for Reconsideration to preserve the issue and failed to do so.

Thus, the sole issue before the Court was whether the process for obtaining a second opinion was complete before the employee underwent her spinal surgery in January 2006. The Court found the Board's interpretation of the second opinion as constituting a grudging recommendation of surgery to be so entirely at odds with the plain text of the July 2005 report that it was "an irrational inference." Therefore, the process had not been completed with a concurring second opinion. Rather, there were conflicting opinions, the second of which the parties had agreed to accept. Since Applicant underwent self-procured spinal surgery before the resolution of a renewed second-opinion process, the employer was found not to be liable for the costs.

XII. Lien Claims and Costs

Costa v. Hardy Diagnostic (2007) 72 CCC 1492, Appeals Board en banc opinion.

The Appeals Board issued an en banc decision in *Costa v. WCAB* (2006) 71 CCC 1797, finding that the applicant had not met his burden of proving the invalidity of the 2005 PDRS and that the costs of obtaining evidence to rebut the PDRS may be allowable. Specifically, the Board reversed the finding of the WCJ denying reimbursement for the costs of Applicant's rehabilitation expert, and ordered the costs to be adjusted. The Board stated that the expert was entitled to be paid for her testimony and also for her report, in spite of the fact that it had been excluded from evidence, to the extent that "some of her work in preparing that report may have provided a foundation for her testimony."

Defendant filed a Petition for Reconsideration from the latter finding contending that the Board erred on a number of grounds.

In its second *Costa* decision, the Board reiterated its prior finding that Labor Code § 4660 continues to allow the parties to present evidence on and/or in rebuttal to a permanent disability rating under the new PDRS, and that the costs of such evidence may be allowable. Regarding the standards for the allowance of such costs, the Board first observed that before costs may be allowed for testimony and/or reports of an expert witness, that person must, of course, qualify as an expert. While vocational rehabilitation counselors would appear, in general, to be qualified with respect to diminished future earning capacity (DFEC) issues under the new PDRS, the qualifications of each purported expert must be determined on a case by case basis.

Once a witness has been qualified as an expert, the costs of the expert's testimony and/or his or her reports may be allowable under Labor Code § 5811 by applying standards similar to the standards for allowing medical-legal costs under § 4621(a) which provides, in pertinent part as follows:

“[T]he employee ... shall be reimbursed for his or her medical-legal expenses reasonably, actually and necessarily incurred The reasonableness of, and necessity for, incurring these expenses shall be determined with respect to the time when the expenses were actually incurred.”

As with medical-legal costs, which may be reimbursable even though the applicant is unsuccessful in his or her claim, the expert evidence offered by an applicant does not necessarily have to successfully affect the permanent disability rating to be reimbursable. However, the WCAB has the discretion to balance the amount of such costs against the benefit obtained.

Additionally, the Board found that, as with medical-legal costs, reimbursement will not be allowed if the report and/or testimony is premised on facts or assumptions so false as to render it worthless as evidence. Furthermore, as medical-legal costs are not recoverable with respect to reports that are incapable of proving or disproving a disputed fact, or whose conclusions are totally lacking in credibility, reports and testimony of a vocational rehabilitation expert must at least have the potential to affect a permanent disability rating in order for their costs to be recoverable.

The Appeals Board affirmed its prior decision, as amended, and returned the matter to the trial level for further proceedings and decision consistent with its opinion.

Stokes v. Patton State Hospital (2007) 72 CCC 996, Appeals Board
Significant Panel Decision.

The WCJ disallowed the lien claim of an outpatient surgery center on the sole ground that it “did not have a fictitious-name permit issued by the Division of Licensing of the Medical Board of California prior to rendering professional services.” The surgery center

petitioned for reconsideration, claiming that that because it was only claiming “facility fees” and not “professional fees,” it did not need a fictitious-name permit from the Medical Board, and that it possessed all the required licenses and accreditations necessary to support its billing.

The Appeals Board panel rescinded the decision of the WCJ and returned the matter to the trial level for further proceedings to address whether the surgery center was claiming to have provided medical treatment to Applicant as a “clinic” that is required to have a fictitious-name permit and license from the Medical Board, or as an “outpatient setting” that is not required to have a license or fictitious-name permit from the Medical Board if properly accredited by an agency recognized by the Medical Board.

Vega v. Barrett Business Services (2007) 35 CWCR 244, Appeals Board panel decision.

Citing Labor Code §§4620 and 4622, and AD Rules §9795.3, the WCJ awarded a 10 percent penalty and interest to an interpreter who provided services at a District Office hearing and whose payment was unreasonably delayed. Defendant petitioned for reconsideration. In his report, the WCJ stated that sanctions were merited in view of the long delay in payment. However, he conceded that there was merit to Defendant’s argument that the cited statutes and regulation only covered medical-legal expenses.

Pursuant to the WCJ’s recommendation, the Appeals Board granted reconsideration and amended the WCJ’s F & A by changing the finding in question to read: “No penalties or pre-judgment interest are payable under Labor Code §§4620, 4622, and 5811, or under Cal.Code.Reg., tit.8, §§89795.3, 9795.4.”

Lyngso Garden Materials, Inc. v. WCAB (2007) 72 CCC 1097, Court of Appeal, First Appellate District, Division Two, unpublished opinion.

Applicant sustained a cumulative trauma ending in December 2004. His disability became permanent and stationary in August 2005. The matter came on for trial and Applicant presented the testimony of a vocational rehabilitation expert on the issue of diminished future earning capacity. The WCJ awarded permanent disability based on the 1997 PDRS and ordered Defendant to pay the fees of the vocational rehabilitation expert as an item of costs under Labor Code §5811. Defendant petitioned for reconsideration which was denied. It then sought judicial review which was granted.

Relying on *Costco v. WCAB (Chavez)* (2007) 72 CCC 582, the Court found the 2005 PDRS to be applicable. Regarding the fees of the rehabilitation expert, the Court noted that the primary issue at trial was whether the 1997 or the 2005 PDRS applied. Although the WCJ and the Appeals Board did not assess future earning capacity due to their erroneous utilization of the 1997 schedule, future earning capacity was an issue “squarely presented” as a result of Defendant’s contention that the 2005 schedule applied. Therefore, it was appropriate to allow Applicant costs under Labor Code §5811 for the fees of his expert witness on this issue.

Cross-reference

California Insurance Guarantee Association v. WCAB (Gutierrez) – See Insurance Coverage/CIGA

Blue Cross of California v. WCAB (Gorgi) – See Insurance Coverage/CIGA

XIII. Vocational Rehabilitation

Gamble v. WCAB (2006) 71 CCC 1015, Court of Appeal, Fourth Appellate District, Division Three.

Applicant was injured while working for an airline. He had a second job working for a school district. His injury prevented him from performing his pre-injury job duties for the airline. However, he was able to continue working for the school district. The WCJ ordered the employer airline to provide Applicant with VRMA benefits, but allowed the airline a credit against VRMA for wages he earned at his concurrent employment. After Applicant petitioned for reconsideration, the WCJ amended the Award to eliminate the credit. However, the Appeals Board then granted the defendant's Petition for Reconsideration and reinstated the credit. Applicant filed a Petition for Writ of Review, contending that the credit unfairly penalizes an injured employee who works two jobs and amounts to a windfall to the employer as a result of the worker's diligence.

The Court found it to be significant that when the Legislature created the maintenance allowance for permanently disabled workers, it capped the payment at an amount that was less than what a temporarily disabled worker would receive, based on a preset fraction of the worker's average weekly wage. Although it was foreseeable that permanently disabled workers could be collecting permanent disability indemnity as well as income from second jobs, there is no indication that the Legislature contemplated a credit for wages to employers paying VRMA. Just as an injured worker can supplement VRMA with permanent disability payments without fear of losing benefits, the Court held that the employee can continue to earn wages at a second job while being rehabilitated into new employment to replace the job that has been precluded on account of the injury. Thus, the Court concluded that Applicant was entitled to all components of VRMA benefits simply because he was a QIW and Defendant was not entitled to a credit for wages earned in the second employment.

That portion of the order allowing the credit was annulled and the matter remanded for further proceedings.

XIV. Permanent Disability**A. In General**

Linam v. WCAB (2007) 72 CCC 332, Court of Appeal, Fifth Appellate District, unpublished opinion.

Relying on the opinion of Applicant's QME and rejecting the opinion of his vocational counselor, the WCJ found him to be 88 percent permanently disabled. Applicant filed a Petition for Reconsideration, contending the WCJ erred in apportioning any permanent disability to nonindustrial factors and that he was therefore 100 percent permanently disabled pursuant to the opinion of his vocational counselor. The Appeals Board affirmed the WCJ's finding of permanent disability. Applicant filed a Petition for Writ of Review.

Applicant argued that the counselor's testimony that he was unemployable established his right to a 100 percent Award pursuant to the holding in *LeBoeuf v. WCAB* (1983) 48 CCC 587. However, she also testified that the work-related injury only caused 80 to 90 percent of Applicant's inability to work, with the remaining due to his preexisting limited health, vision, education, and literacy. Applicant contended that the reduction to 88 percent was the result of apportionment impermissibly based on the opinion of a non medical expert, namely the same vocational counselor that found him to be unemployable. The Court noted that while evidence of unemployability, based on the opinion of a vocational counselor, is relevant, it is not controlling. Additionally, the Appeals Board did not rely on the counselor's opinion in determining the level of permanent disability. Therefore, the Petition for Writ of Review was denied.

B. Application of Proper PDRS

Zenith Insurance Company v. WCAB (Cugini) (2008) 73 CCC _____, Court of Appeal, Second Appellate District, Division Seven, published opinion. (Filed January 29, 2008)

Applicant sustained a back injury in June 2004. On December 28, 2004, while he was still receiving TTD, his PTP stated in a 3 sentence report:

"I am a treating physician for the above-referenced applicant. There is a reasonable medical probability that permanent disability exists as a result of the injury or injuries for which I am treating this patient. I will describe that disability further in a subsequent report."

Applicant underwent surgery in March 2005 and was declared P & S by the PTP in December 2005 with 42 percent PD under the old schedule and a 13 percent whole person impairment under the new PDRS. Defendant's QME found him to be P & S in October 2005 with a 13 percent whole person impairment under the new schedule.

At trial, the WCJ found the old schedule to be applicable based on a panel decision that the obligation to send a Labor Code § 4061 notice arises with the first payment of TD. Defendant's Petition for Reconsideration was denied with one Commissioner disagreeing that the duty to provide notice under § 4061 arose in 2004, but concluding that the PTP's December 28, 2004, report "is a report by a treating physician indicating the existence of permanent disability." Defendant then sought judicial review.

The Court of Appeal agreed with Defendant that the obligation to send a Labor Code § 4061 notice arises with the last payment of TD and not the first one. However, it agreed with Applicant that the evidentiary value of the PTP's December 28, 2004 should be determined in the context of the entire record. The Court distinguished *State Compensation Insurance Fund. v. WCAB (Echeverria)* (2007) 72 CCC 33 in which a similar PTP report was found not to constitute substantial evidence. In *Echeverria*, the rest of the medical record failed to support the pre-2005 existence of PD whereas in the present case, both the WCJ and one Commissioner found that the record provided the reasoning to support the PTP's opinion.

Thus, the matter was remanded to the Appeals Board to determine whether the PTP's December 28, 2004, report, or any other qualifying report, indicates the existence of PD under Labor Code § 4660(d).

Genlyte Group v. WCAB (Zavala) (2008) 73 CCC ____, Court of Appeal, Second Appellate District, Division Seven, published opinion. (Filed January 3, 2008)

Applicant sustained a 2001 specific injury and a cumulative trauma ending in 2003. Her PTP reported in September 2004: "It is my opinion that permanent disability exists with respect to the patient's bilateral shoulder and bilateral upper extremity injuries, however, I will further determine the extent of permanent disability after further evaluations of the patient's condition." This opinion was reiterated in reports that issued in October and November 2004 which also indicated Applicant "will more than likely require vocational rehabilitation, but this will be determined after further evaluation." In October 2005, the PTP reported that Applicant was permanent and stationary with work restrictions and that vocational rehabilitation was required. He also reported impairment pursuant to the AMA Guides.

Previously, in April 2004, Defendant obtained the opinion of a QME who reported that Applicant was not permanent and stationary, but that she would be a QIW. He further stated, "At the present time, the presence of permanent impairment is expected, but rating is uncertain." The QME found Applicant to be permanent and stationary in August 2005 and also indicated that she required vocational rehabilitation.

The matter came on for trial and the WCJ awarded temporary disability until October 2005 when Applicant became permanent and stationary. She also found that Applicant's permanent disability should be rated under the 1997 PDRS because the April 2004 report of Defendant's QME was a comprehensive medical-legal report within the exception of

Labor Code § 4660(d). Defendant petitioned for reconsideration, contending, as it had at trial, that the 2005 schedule should have been used to rate Applicant's permanent disability the defense QME's comprehensive medical-legal report indicated she was not permanent and stationary and, although permanent disability was expected, it did not currently exist.

In her report on reconsideration, the WCJ explained that the QME's pre-2005 report satisfied the requirement of Labor Code § 4660(d) and Defendants had provided no authority for the position that the qualifying words "indicating the existence of permanent disability" applied not only to a treating physician's report but also to a comprehensive medical-legal report. The WCAB adopted the WCJ's report and denied Defendant's petition, basing its decision on its en banc opinion in *Baglione v. Hertz Car Sales* (2007) 72 CCC 86. Defendants then sought judicial review.

The Court of Appeal disagreed with the Appeals Board and concurred with the decision of another appellate district in *Costco v. WCAB (Chavez)* (2007) 72 CCC 582, holding that a comprehensive medical-legal report, like a treating physician's report, must contain an indication of the existence of permanent disability to trigger use of the pre-2005 rating schedule. The Court noted that Defendant's position was supported by *Vera v. WCAB* (2007) 72 CCC 1115, which observed that the terms "permanent disability" and "permanent and stationary status" are used interchangeably in the applicable administrative regulations and therefore concluded it was appropriate to presume the Legislature was aware of that interchangeable use when it drafted Labor Code § 4660(d). Accordingly, the *Vera* Court held that the Legislature intended the former PDRS to apply to a claim arising before January 1, 2005 only when a treating physician's report indicates the applicant's condition has become permanent and stationary.

Declaring that Defendant's argument and the *Vera* Court's conclusion "miss the mark," the Court pointed out that § 4061 requires notice by the employer together with the last payment of TD that (i) no PD is payable, (ii) the amount that is payable or (iii) "that PD may be or is payable, but that the amount cannot be determined because the employee's medical condition is not yet permanent and stationary. Thus, it is not true that the two terms are invariably used interchangeably or that it should be concluded that the Legislature intended "permanent and stationary" when it actually said "permanent disability." Furthermore, vocational rehabilitation, which is based on permanent disability, is properly initiated as soon as it is apparent that the worker is a QIW and ideally before permanent and stationary status is achieved.

Thus, the Court remanded the matter to the Appeals Board to determine whether the Defense QME's April 2004 report or the PTP's 2004 reports constitute substantial evidence "indicating the existence of permanent disability" under section 4660(d) and, based on that determination, to apply either the 1997 or the 2005 PDRS in issuing an award to Applicant.

The Second Appellate District's *Zavala* decision is in direct conflict with *Vera v. WCAB*, a published decision that issued out of the Fourth Appellate District. Therefore, it may be necessary for the Supreme Court to resolve the issue, just as it did in *Brodie v. WCAB*.

Tanimura & Antle v. WCAB (Lopez) (2007) 72 CCC 1579, Court of Appeal, Sixth Appellate District, published opinion.

Applicant sustained an injury in September 2004 and received TD payments up until March 2006. An AME determined that he became permanent and stationary in January 2006 and the parties agreed that PD payments were to commence in March 2006. The parties disagreed whether the 1997 or 2005 PDRS would apply although they agreed on the percentage of disability under each schedule.

After a trial, the WCJ ruled that the 2005 schedule applied because the case did not fall under any of the exceptions to the new PDRS set forth in Labor Code §4660(d). Applicant filed a Petition for Reconsideration and in a split decision, the panel reversed the WCJ and found that the 1997 PDRS should apply based on the fact that the duty to give notice under § 4061 arose when the first payment of TD was made in September of 2004. The defendant then filed a Petition for Writ of Review.

The Court of Appeal noted that a conclusion contrary to that of the Appeals Board had been drawn in *Costco v. WCAB (Chavez)* (2007) 72 CCC 582, and that the same conclusion had been reached in a number of other appellate decisions. In expressing its approval of those decisions, the Court stated that "a construction of section 4660, subdivision (d), to require no indication of permanent disability . . . would be contrary to the spirit of the statute and the workers' compensation reform package as a whole."

The Court annulled the Appeals Board's opinion and decision after reconsideration and remanded the case with instructions to award Applicant compensation in accordance with the decision of the WCJ.

Costco v. WCAB (Chavez) (2007) 72 CCC 582, Court of Appeal, First Appellate District, Division Four, published opinion.

Applicant was injured in June 2004. He was off work for two days and then placed on light duty work, which he continued to do until he was terminated in late 2004. He was evaluated by a QME who issued a report on September 2004, in which he stated that Applicant was not permanent and stationary at that time, but that he was "expected to be permanent and stationary hopefully in the next 90 days to 120 days." The report did not state whether any of Applicant's conditions would result in permanent disability.

After a trial, the WCJ found that Applicant's permanent disability should be rated using the 1997 PDRS. Defendant filed a Petition for Reconsideration and the Appeals Board affirmed the WCJ's decision on the ground that the correct construction of the pertinent

sentence, in Labor Code §4660(d) “*when there has been either no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability,*” requires a report by a treating physician to indicate the existence of permanent disability, while a comprehensive medical-legal report does not require an indication of permanent disability.” Defendant sought judicial review of this decision, contending that the phrase “indicating the existence of permanent disability” applies both to a report by a treating physician and to a comprehensive medical-legal report.

The Board had based its interpretation on the “last antecedent rule,” reasoning that the lack of a comma after the word “physician” in the phrase, “no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability” signified that the Legislature intended the words “indicating the existence of permanent disability” to apply only to the immediate antecedent—the report by a treating physician.

While acknowledging that such an interpretation might be grammatically sound, the Court found the argument to be unpersuasive. The Court observed that a pre-2005 medical-legal report written about issues other than permanent disability, or a report that considered the issue but found no permanent disability, would supply no logical basis for applying the earlier rating schedule. Furthermore, to require no indication of permanent disability in a comprehensive medical-legal report, would be contrary to the spirit of the statute and the workers’ compensation reform package as a whole.

Additionally, the Court noted that a “parallel provision” in Labor Code §4658(d) contains the necessary comma and there would be no reason for the Legislature to have a different type of medical-legal report serve as the demarcation for permanent disability ratings and permanent disability compensation schedules.

The Court also disagreed with Applicant’s second contention that the Board’s decision should be upheld because the second circumstance listed in §4660(d) required the employer to provide the notice required by §4061 to the injured worker, thus triggering the earlier schedule. Applicant’s temporary disability benefits were not terminated until 2005 and it was only then that the employer was obligated to send the requisite notice. Since it would be rare for TD payments not to be owed or paid prior to 2005 for an injury occurring in a prior year, the Court felt that such a limited exception would be pointless where the Legislature could more easily have drafted the statute to apply the schedule in effect on the date of injury in all cases.

Thus, the Court found that Applicant’s permanent disability must be rated under the 2005 schedule.

Chang v. WCAB (2007) 72 CCC 921, Court of Appeal, Third Appellate District, published opinion.

Applicant sustained an industrial cumulative trauma injury in 2004 that became permanent and stationary in 2005. The WCJ The workers’ compensation judge

determined that none of the three exceptions to Labor Code §4660(d) applied and therefore her permanent disability should be evaluated under the permanent disability rating schedule (PDRS) that became effective January 1, 2005. Applicant sought reconsideration, arguing that the Board's en banc decision in *Aldi v. Carr, McClellan, Ingersoll, Thompson & Horn* (2006) 71 CCC 783 was wrongly decided. Bound to follow the Board's decision, the WCJ recommended denial of her petition. The Board adopted the WCJ's report and denied the Petition for Reconsideration. Applicant filed a Petition for Writ of Review.

The sole question of law presented to the Court of Appeal was whether Labor Code §4660, as amended in 2004, requires the use of the 2005 PDRS to apply to injuries sustained before the schedule was adopted when none of the three exceptions set forth in the third sentence of §4660(d) apply. That third sentence provides as follows:

“For compensable claims arising before January 1, 2005, the schedule as revised pursuant to changes made in legislation enacted during the 2003-04 Regular and Extraordinary Sessions shall apply to the determination of permanent disabilities when there has been either no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability, or when the employer is not required to provide the notice required by Section 4061 to the injured worker.”

The Court noted that it was required construe the meaning of §4660 de novo, but would accord great weight to the Board's construction in *Aldi* unless it was clearly erroneous. The Board in *Aldi* explained that,

“...the third sentence of section 4660(d) provides a clear and specific exception to the general rule of prospective application as stated in the second sentence, and mandates the application of the revised rating schedule to injuries occurring before January 1, 2005, in specified instances...Thus, for all pending cases involving injuries occurring prior to January 1, 2005, the revised schedule must be applied unless one of the listed exceptions has been established. Only in those cases where it can be established that at least one of the listed exceptions exists would the prior rating schedule still apply.”

Applicant challenged the Board's interpretation of the legislative intent, considering the fact that the second sentence of the statute mandates prospective application. She contended that if the administrative director had adopted a revised schedule after April 19, 2004, but before January 1, 2005, only then would the revised schedule apply to injuries sustained during 2004. Since the new schedule did not become effective until January 1, 2005, however, the third sentence of subdivision (d) became moot.

The Court noted that the Board in *Aldi* rejected the identical argument, explaining that such statutory interpretation did not follow the requirement that meaning be given to every word or phrase and to not 'render any portion of the statutory language mere surplusage.' While being mindful of the rule of liberal construction set forth in Labor Code §3202, the Court stated that the so-called "liberality rule" cannot supplant the intent of the Legislature as expressed in a particular statute. Therefore, the decision of the Board was affirmed

Zenith Insurance Company v. WCAB (Azizi) (2007) 72 CCC 785, Court of Appeal, First Appellate District, Division Three, published opinion.

Applicant was injured in October 2004. His condition was declared permanent and stationary in August 2005 at which time the carrier terminated temporary disability benefits. After a trial, the WCJ found that the 2005 PDRS applied. Applicant petitioned for reconsideration and the Appeals Board reversed the WCJ, concluding that the 1997 schedule applied because notice was required under Labor Code §4061 prior to January 1, 2005. Defendant sought judicial review.

Applicant contended that Defendant was required to give notice under §4061 before January 1, 2005, because the duty to provide such notice arises when temporary disability payments are commenced rather than when they are terminated. The Court disagreed, citing *Costco v. WCAB (Chavez)* (2007) 72 CCC 582.

Applicant's alternative argument was that the third sentence of Labor Code §4660(d), which extends the new schedule to pre-2005 claims, conflicts irreconcilably with the second sentence of the same subdivision, which states the more general rule that the schedule "shall apply prospectively and shall apply to and govern only those permanent disabilities received or occurring on and after the effective date and adoption of the schedule, amendment or revision, as the case may be." Thus, the new schedule would have only been extended to pre-2005 claims if the schedule had been adopted prior to January 1, 2005. In rejecting this argument, the Court observed that if the Legislature had meant to target only those injuries arising during the period between April 19, 2004, and the implementation of the new PDRS, it presumably would have done so explicitly rather than by making a blanket reference to claims arising before January 1, 2005.

The Court therefore annulled that portion of the Award applying the 1997 PDRS.

Energetic Painting and Drywall, Inc. (Ramirez) v. WCAB (2007) 72 CCC 937, Court of Appeal, Third Appellate District, published opinion.

Applicant was injured in July 2004 and received temporary disability benefits until March 2005. The WCJ calculated his permanent disability Award using the 1997 PDRS, adopting the reasoning of two earlier decisions by Appeals Board panels. Defendant petitioned for reconsideration. While its petition was pending, the Appeals Board issued its first decision in *Pendergrass v. Duggan Plumbing* (2007) 72 CCC 95 in which a four-member majority agreed with the reasoning of the panel decisions on which the WCJ in this case had relied. Thus, the Appeals Board affirmed the decision of the WCJ. Defendant then filed a Petition for Writ of Review. While that petition was pending, the Appeals Board granted reconsideration in *Pendergrass* and issued a new opinion that reached the opposite conclusion. (*Pendergrass v. Duggan Plumbing* (2007) 72 CCC 456.)

After Defendant's writ was granted, the First Appellate District issued its decision in *Costco v. WCAB (Chavez)* (2007) 72 CCC 582. In this case, the Court agreed with the new majority in *Pendergrass* that an employer "is required" to give notice under Labor

Code §4061, within the meaning of §4660(d), when the employer makes the last payment of temporary disability benefits, not when those payments commence. The Court “wholeheartedly” agreed with the reasoning of the *Costco* Court, stating:

“To conclude, as the original majority in *Pendergrass* did, that an employer is required to provide the section 4061 notice as soon as the first payment of temporary disability indemnity is made, even though that requirement does not have to be satisfied until the last payment is made, simply stretches the statutory language beyond its plain and ordinary meaning.”

The Appeals Board’s order denying Defendant’s Petition for Reconsideration was annulled and the matter remanded for further proceedings

Vera v. WCAB (2007) 72 CCC 1115, Court of Appeal, Fourth Appellate District, Division One, published opinion.

In connection with a 2003 injury, Defendant provided Applicant with temporary disability benefits until February 2005 and thereafter, paid permanent disability advances. Applicant’s treating physician wrote a report in April 2004 stating that he “currently” had the existence of permanent disability and listing work restrictions “on a preliminary basis.” The parties litigated their dispute concerning the application of the proper PDRS. The WCJ found that the 1997 schedule applied.

Defendant petitioned for reconsideration and in a split decision, the panel majority applied the 2005 PDRS, stating that “having permanent disability ‘on a preliminary basis,’ is not the same as ‘the existence of permanent disability.’” The dissenting Commissioner believed that the April 2004 medical report together with an abnormal MRI was enough to indicate the existence of permanent disability. Applicant then filed a Petition for Reconsideration, further arguing that since his employer was subsequently required subsequently to provide a Labor Code §4061 notice, the old schedule applies. This petition was denied in another 2-1 decision. Applicant then filed a Petition for Writ of Review that was granted.

The Court first held that January 1, 2005 was the cut-off date for the existence of the three circumstances described in Labor Code §4660(d). Regarding the exception that occurs “when there has been . . . no report by a treating physician indicating the existence of permanent disability,” the Court found that the treating physician’s report must indicate that the applicant has a ratable disability that has reached permanent and stationary status. The Court believed this interpretation was supported by the fact that regulations use the terms “permanent and stationary status” and “permanent” disability interchangeably when describing the status of a disability. Because the treating physician’s report indicated that Applicant’s status was not permanent and stationary, there was no “report from a treating physician indicating the existence of permanent disability.”

Based on the plain language of the statute, the Court also held that the 1997 PDRS applies if, before January 1, 2005, the employer makes or is required to make the last payment of temporary disability benefits. This interpretation was further supported by the fact that an employer who prepares a Labor Code §4061 notice will generally conduct an analysis to determine the permanent disability benefits that it believes are payable. This analysis requires the application of a schedule for rating permanent disabilities. Therefore, the Court's interpretation would preserve continuity in the parties' dealings and to save the employer from having to conduct a *new* analysis and send a *new* notice premised on the *new* schedule.

Therefore, the Court held that the 2005 schedule was applicable to Applicant's case and the decision of the Appeals Board was affirmed.

State Compensation Insurance Fund. v. WCAB (Echeverria) (2007) 72 CCC 33, Court of Appeal, First Appellate District, Division One.

Applicant was injured in July 2004 and became permanent and stationary in June 2005. In December 2004, his treating physician signed and dated a statement prepared by Applicant's attorney that read as follows: "*I believe permanent disability is within reasonable medical probability emanating from this injury.*" The matter came on for trial and the WCJ found that this statement, coupled with the doctor's prior reports, amounted to a "report by a treating physician indicating the existence of permanent disability." This brought the case under one of the exceptions listed in Labor Code §4660(d) that permitted rating under the 1997 PDRS. On reconsideration, the Appeals Board agreed with the WCJ.

The Court concluded that conclude the Appeals Board's decision was not supported by substantial evidence. In order to constitute substantial evidence, a medical report must indicate the reasoning behind the doctor's opinion. The treating physician's prior reports described spinal range of motion problems. However, nothing in those reports appeared to tie the range of motion and pain symptoms to the doctor's prediction of permanent disability contained in his December 2004 statement.

Under the circumstances, the Court found it unnecessary to address the defendant's contention that "a report by a treating physician indicating the existence of permanent disability" is necessarily contradicted and defeated by the fact that a worker is temporarily totally disabled and has not been declared permanent and stationary at the time the report is issued. the Board's decision was annulled and remanded for further proceedings.

Baglione v. Hertz Car Sales (2007) 72 CCC 86 and 72 CCC 444, *Appeals Board en banc opinions.*

Applicant was injured in 2003 and became permanent and stationary in 2005. The WCJ determined that his permanent disability should be rated under the 2005 PDRS because none of the exceptions set forth in Labor Code §4660(d) for using the 1997 PDRS were

applicable, and specifically that there was neither a report from a treating physician nor a comprehensive medical-legal report indicating the existence of permanent disability. Applicant petitioned for reconsideration, contending that his permanent disability should have been rated under the 1997 PDRS because a comprehensive medical-legal report issued in 2004, although it did not indicate the existence of permanent disability.

In a 4-3 split decision, the Appeals Board determined that the Legislature did not intend to require that a comprehensive medical-legal report indicate the existence of permanent disability in order for the 1997 PDRS to apply.

Defendant petitioned for reconsideration, being newly aggrieved. As a result of an intervening change in the composition of the Appeals Board, a new en banc decision issued on April 6, 2007, reversing the Board's former decision. In another 4-3 split decision, the Board held that in order for the 1997 PORS to apply, a pre-2005 comprehensive medical-legal report must indicate the existence of permanent disability

Pendergrass v. Dugan Plumbing (2007) 72 CCC 95 and 72 CCC 456,
Appeals Board en banc opinions.

Applicant sustained an injury in June 2004. Defendant accepted liability and paid temporary disability continuously until July 2005. The matter proceeded to trial primarily on the issue of whether applicant's permanent disability should be determined under the 1997 PDRS or the 2005 Schedule based on the AMA Guides. The WCJ applied the 2005 PDRS, reasoning that none of the three exceptions in Labor Code §4660(d) that require application of the 2005 Schedule to pre-2005 injuries, were applicable to this case. Applicant sought reconsideration, contending that the 1997 Schedule was applicable because Defendant's obligation to provide notice required pursuant to §4061 arose in June 30, 2004, when temporary disability commenced.

In a 4-3 split decision, the Appeals Board held that that an employer's duty "to provide the notice required by" section 4061 arises with the first payment of temporary disability indemnity, drawing a distinction between when the duty arises and when the duty is required to be executed.

Defendant then petitioned for reconsideration, being newly aggrieved. As a result of an intervening change in the composition of the Appeals Board, a new en banc decision issued on April 6, 2007, in which the Board reversed its former position in another 4-3 split decision. The Board held that in order for the 1997 PORS to apply, the defendant must have issued the last payment of temporary disability prior to January 1, 2005 since it is the last payment that triggers the obligation to serve the Labor Code §4061 notice.

Trader Joe's Company v. WCAB (Evets) (2007) 72 CCC 204, Court of
Appeal, First Appellate District, Division Three, unpublished opinion.

Applicant sustained a crush injury to his hand in January 2004. Several doctors reported during the year 2004 that he had limited range of motion and nerve damage, but none of them stated the condition would be permanent. A QME reporting in October 2005 stated

that his condition became permanent and stationary when he was released to return to work in March 2005. After a trial on the issue of which permanent disability rating schedule (PDRS) was applicable, the WCJ initially applied the 2005 PDRS. However, after Applicant petitioned for reconsideration, he amended the decision to find that since several of the 2004 reports discussed medical findings that were indicative of permanent disability, the matter should be rated under the 1997 PDRS. Defendant then filed a Petition for Reconsideration that was denied by the Appeals Board.

The Court of Appeal granted Defendant's Petition for Writ of Review. It noted that although Applicant's injuries were listed in the AMA Guides, there was nothing in the record that established that Applicant's nerve damage and reduced range of motion were necessarily permanent as of December 31, 2004, that "the mere mention of a condition that *could* result in permanent disability is insufficient." That portion of the Award applying the 1997 PDRS was vacated and remanded for recalculation of Applicant's permanent disability under the 2005 schedule.

Unpublished Appellate Decisions following Baglione, Pendergrass and Costco		
District	Division	Case
First	One	<i>Washington Mutual Bank v. WCAB</i> (2007) 72 CCC 962 <i>San Francisco Marriott v. WCAB</i> (2007) 72 CCC 1103 <i>UC San Francisco v. WCAB</i> (2007) 72 CCC 1108
	Two	<i>Lyngso Garden Materials v. WCAB</i> (2007) 72 CCC 1097
	Four	<i>Minatta Transportation Co. v. WCAB</i> (2007) 72 CCC 950 <i>Health Net, Inc. v. WCAB</i> (2007) 72 CCC 1093
	Five	<i>Zenith Insurance Co. v. WCAB</i> (2007) 72 CCC 1135
Second		
Third		<i>City of Galt v. WCAB</i> (2007) 72 CCC 1197 <i>Travelers Indemnity Co. v. WCAB</i> (2007) 72 CCC 1233
Fourth	One	<i>City of San Diego v. WCAB</i> (2007) 72 CCC 1071
Fifth		<i>Serrano v. WCAB</i> (2007) 72 CCC 1574 <i>Valadez v. WCAB</i> (2007) 72 CCC 1379 <i>Joiner v. WCAB</i> (2007) 72 CCC 943
Sixth		<i>Bed, Bath & Beyond v. WCAB (Costa)</i> (2007) 72 CCC 1565
		<i>HSR, Inc. v. WCAB</i> (2007) 72 CCC 1211

XV. Apportionment**A. Labor Code §4663**

Benson v. The Permanente Medical Group (2007) 72 CCC 1620, Appeals Board en banc decision.

Applicant, a file clerk, whose job involved repetitive neck and upper extremity motion, was reaching up over her head, pulling out a plastic bin, when she felt a pain in her neck. She filed an Application for Adjudication claiming a specific injury and ultimately underwent a three-level fusion of the cervical spine. She was evaluated by an AME who concluded that she had sustained both a specific injury and a cumulative trauma which became permanent and stationary at the same time. Regarding apportionment, the AME concluded that her semi-sedentary restriction was equally caused by both injuries.

At trial, Defendant contended that the apportionment provisions in SB 899 abrogated the rule in *Wilkinson v. WCAB* ((1977) 42 CCC 406, and mandated that Applicant receive two separate awards of 31% permanent disability. The WCJ found that the *Wilkinson* rule was still viable and that separate awards of permanent disability were not required. Accordingly, she issued a single Award based on the combined permanent disability of 62%. Defendant then sought reconsideration.

A majority of the Appeals Board, sitting en banc, noted that under the rule set forth in *Wilkinson*, an injured worker could receive a single combined Award of permanent disability where successive injuries to the same body part became permanent and stationary at the same time. When *Wilkinson* was decided, former Labor Code § 4750 had provided that if an injured worker suffered from a previous permanent disability or physical impairment, the employer could only be held liable for the disability arising out of the immediate industrial injury. In its opinion in *Wilkinson*, the Supreme Court concluded that “[i]f the worker incurs successive injuries which become permanent *at the same time*, neither permanent disability is ‘previous’ to the other, and section 4750 hence does not require apportionment.”

SB 899 repealed Labor Code § 4750 and changed the rules of apportionment. Under new section 4663, apportionment must be based on causation and must be determined based on the approximate percentage of permanent disability caused by the direct result of injury and the percentage caused by other factors. New § 4664 provides that an employer is now only “liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment.”

In *Brodie v. WCAB* (2007) 72 CCC 565, the Supreme Court made the following observation:

“[t]he plain language of new sections 4663 and 4664 demonstrates they were intended to reverse [certain] features of former sections 4663 and 4750”...and that, in enacting SB 899, the Legislature created a new “causation regime,” requiring that all potential causes

of permanent disability be separately addressed and considered when apportioning disability pursuant to newly revised Labor Code section 4663...”

“...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. Thus, repeal of section 4750 was necessary to effect the Legislature's purposes in adopting a causation regime.”

The Appeals Board recognized that in *Brodie*, the Court considered the question of whether the repeal of § 4750 required the rejection of the formula in *Fuentes v. WCAB* (1976) 41 Cal.Comp.Cases 42, but found the Legislature’s “silence” on the subject to evidence no such intent. However, the Board found no such silence in connection with the *Wilkinson* issue. Rather, it found that “the plain language of the sections expresses – or, at least, necessarily implies – a legislative intent to abrogate the rule in *Wilkinson* due to the new causation regime created by SB 899.” The statutory language “unambiguously mandates apportionment to causation of disability in all cases, including successive industrial injuries to the same body part that become permanent and stationary at the same time.”

Additionally, SB 899 clearly stated its intent to provide immediate relief from the crisis of skyrocketing workers’ compensation costs. In successive injury cases, a single combined Award of permanent disability is dramatically more costly than two separate smaller awards. The Board further rejected the argument that Labor Code § 4663 did not provide for apportionment to causation where the employee’s “other factors” of disability are concurrent with the disability caused by the industrial injury. Subdivision (c) 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.

In *Wilkinson*, the Supreme Court had reasoned that any attempt by a physician to allocate the combined disability between multiple injuries may be “impossible or inequitable” and “is likely to be no more than speculation and guesswork.” However, in all workers’ compensation claims, including those involving successive industrial injuries, § 4663 now specifically requires that a reporting physician “shall ... address the issue of causation of the permanent disability.” The Board observed that medicine is not an exact science and there will always be an element of speculation. This does not mean that a physician’s conclusions are speculative when based on medical judgment and expertise.

In spite of its previously expressed conclusions, the Board majority made the following comment:

“Nevertheless, in a successive injury case, a physician might conclude that at least *some* of the employee’s permanent disability is causally related to each of the injuries, but, as suggested by *Wilkinson*, the physician might not be able to medically parcel out the degree to which each injury is causally contributing to the employee’s overall permanent disability, even after complying with the statutory mandate of consulting with another

physician – or referring the employee to another physician – in order to assist with the apportionment determination. In such an instance, the physician’s apportionment “determination,” within the meaning of section 4663, could properly be that the approximate percentages of disability caused by each of the successive injuries cannot reasonably be determined. As a result, the employee would be entitled to an undivided (i.e., joint and several) award for the combined permanent disability, because the respective defendants would have failed in their burdens of proof on the issue of apportionment.”

Thus, the WCJ’s finding that applicant is entitled to a combined Award of 62% permanent disability was rescinded and the F & A was amended to provide for separate awards of 31% permanent disability for each industrial injury.

One Commissioner dissented contending that the overhaul of the appointment statutes by SB 899 did not effect any change in the longstanding principle of law established by *Wilkinson v. WCAB*. The dissent disagreed with the majority that the plain language of the statutes evidenced a Legislative intent to overturn *Wilkinson*. The Brodie Court had found no intent to abrogate the Fuentes formula in light of the Legislature’s silence on the subject. Therefore, if, in repealing Labor Code § 4750 and enacting new apportionment statutes, the Legislature had intended a departure from *Wilkinson* then “one would expect to find some trace of this intent in the legislative history” and that “[s]uch a change, if intended, would likely have been remarked upon.”

In addition to the absence of any legislative history reflecting an intent to abrogate *Wilkinson*, the dissent found that the plain language of § 4663 is contrary to any such intent. Labor Code § 4663, subdivision (c), provides for the apportionment of disability to “other factors *both before and subsequent* to the industrial injury,” but it does not provide for the apportionment of disability to causation by “other factors” where those factors are caused by successive industrial injuries and are *concurrent with* the factors of disability caused by the first industrial injury. Accordingly, the actual language of § 4663 is consistent with a legislative intent to continue the rule of *Wilkinson*.

Additionally, it would be difficult, if not impossible, for a physician to separate out the factors causing disability as between injuries that become permanent and stationary at the same time such that the concerns that caused the Supreme Court to decision *Wilkinson* in the first place, are still valid. Moreover, if the continued viability of *Wilkinson* is open to some question, then Labor Code § 3202 would mandate that the question be resolved in favor of the injured employee. Finally, the dissent would hold that the AME’s opinion did not constitute substantial evidence to conclude that any portion of Applicant’s disability was caused by cumulative trauma. Thus, the dissenting Commissioner would have affirmed the decision of the WCJ.

Vaira v. WCAB (2007) 72 CCC 1586, Court of Appeal, Third Appellate District, unpublished opinion.

Applicant was 73 years old when she bent over to pick up some travel brochures and suffered a compression fracture of her thoracic spine. An AME apportioned 40 percent of

her permanent disability to pre-existing osteopenia/osteoporosis, and 60 percent to the industrial injury. The parties stipulated to the overall percentage of disability and submitted the issue of apportionment. The WCJ reduced the overall permanent disability based on overlap with a prior injury and found apportionment in accordance with the AME's opinion. Applicant petitioned for reconsideration contending that it was error to reduce the Award both in connection with the overlap and with the apportionment to nonindustrial factors. Adopting the WCJ's recommendation, the Appeals Board denied reconsideration.

The Court of Appeal reviewed the history of Labor Code § 4663 and observed that the prior version of the statute did not permit apportionment to causation or pathology. Rather, it required a showing that the apportioned percentage of permanent disability would have resulted even in the absence of the industrial injury. In contrast, the Supreme Court, in its opinion in *Brodie v. WCAB*, declared that 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. Thus, apportionment to a prior condition that was lighted up, accelerated or aggravated by the current industrial injury is appropriate.

Applicant contended that the AME, and thus the WCAB, confused causation of *injury* with causation of *disability* and that the record did not contain substantial evidence to support the Board's apportionment of 40 percent of her disability to age and osteoporosis. While agreeing with the Appeals Board that substantial evidence supported an apportionment of disability to preexisting conditions, the Court noted that the question was not whether it was proper to apportion *some* disability to preexisting conditions but whether it was proper to apportion *40 percent* of the disability to those conditions. The Court concluded that the Appeals Board may not use risk factors of *injury* in apportioning disability and that it was impossible, on the present record, to determine how much of the 40 percent of disability the AME concluded was caused by preexisting conditions was based on the contribution of those conditions to her industrial injury rather than her industrial disability.

Applicant and amici curiae also argued that any reduction in disability benefits based on her age and osteoporosis amounts to both age and gender discrimination and constitutes a violation of Government Code § 11135. While finding this argument to have merit in the case of apportionment based on age per se, the Court noted that to the extent osteoporosis or some other physical or mental condition that might contribute to a work-related disability arises or becomes more acute with age, it saw no problem with apportioning disability to that condition. On the present record, the Court was unable to determine if the AME, and hence the WCAB, apportioned disability to age per se rather than to one or more physical or mental conditions associated with age that contributed to Applicant's disability.

Applicant further argued that since the parties had stipulated to the overall level of permanent disability, the Board was precluded from reducing that percentage by finding overlap with the prior industrial injury. The Court rejected that argument on the ground

that issue of apportionment necessarily includes any corresponding determination of overlap.

The Court annulled the decision of the Appeals Board and remanded the case for further proceedings consistent with the views expressed in its opinion.

United Airlines v. WCAB (Milivojevich) (2007) 72 CCC 1415, Court of Appeal, Third Appellate District, writ denied.

Applicant suffered an industrially-related stroke and was awarded 91-percent PD, based on the opinion of AME. He filed a Petition to Reopen and was reevaluated by the AME who expressed the opinion that 40 percent of the PD should be apportioned to “elevated serum cholesterol which is clearly above the acceptable normal range.” The WCJ found that Applicant was totally permanently disabled and, following the AME’s apportionment, awarded 96% PD.

Both Applicant and Defendant filed Petitions for Reconsideration. Applicant contended that the WCJ erred in apportioning his PD to non-industrial factors because the AME’s opinion did not constitute substantial evidence. Defendant claimed that the petition was premature because the prior Award had not become final. It further contended that the 40-percent apportionment should be applied to the earlier Award of 91-percent PD rather than limited to any increase in PD. The WCJ recommended that both petitions be denied.

The Appeals Board summarily denied the defendant’s petition. However, it granted Applicant’s Petition for Reconsideration, reversed the WCJ’s determination that Dr. Anderson’s opinion constituted substantial evidence to justify apportionment, noting that the AME did not state that applicant personally suffered from an underlying pathology. Rather, he found that Applicant’s elevated serum cholesterol placed him at greater risk for pathological events, such as stroke and heart attack. In identifying this risk factor, the AME did not distinguish between the causation of injury and causation of disability. Additionally, the AME’s opinion was not framed in terms of reasonable medical probability, and he did not adequately explained the exact nature of the apportionable disability and how and why the disability is causally related to the industrial injury.”

The Board concluded that Defendant failed to meet its burden of proving apportionment and awarded Applicant 100% PD. Defendant filed a Petition for Writ of review which was denied. The Court found no reasonable basis for the petition and remanded the matter for an Award of reasonable attorney fees.

Anderson v. WCAB (2007) 72 CCC 389, Court of Appeal, Second Appellate District, Division Six, published opinion.

Applicant was evaluated by an Agreed Medical Examiner who found that he injured his cervical spine and developed carpal and cubital tunnel syndromes on a cumulative basis as a result of repetitively using his hands to grasp, manipulate, push and pull objects at work. The doctor also found that 30 percent of his upper extremity disability and 20

percent of his cervical disability was caused by “regular activities of life,” such as driving and moving furniture on occasion. The Appeals Board followed the AME’s opinion on apportionment and also found against Applicant on his claim under Labor Code § 132a.

Applicant filed a petition for writ review which was summarily denied. He then sought review by the Supreme Court concerning the Labor Code § 132a issue only. The Supreme Court directed the Court of Appeal to vacate the summary denial and issue the writ of review.

Regarding the apportionment issue, the Court of Appeal cited the Appeals Board’s en banc decision in *Escobedo v. Marshalls* and stated the following:

The physician must arrive at his opinion to a “reasonable medical probability,” and not on “surmise, speculation, conjecture, or guess.” For example, it is insufficient for a physician and Board to say only that some given percentage is “fair,” without providing some pertinent information which supports that determination. The physician should show the reasoning or basis for his or her conclusions, by providing germane facts discovered from an examination of the applicant, his or her medical history, or other pertinent materials. The physician should also discuss the nature of the disease; why it is responsible for the approximate percentage of the PD.

The Court then went on to note that the AME had explained how and why he arrived at his apportionment figures after he examined the applicant, reviewed his medical history, considered his job description and tenure in the position, as well as other historical information including subpoenaed records. He also considered the reports of applicant’s chiropractor.

While the doctor conceded that his percentages were approximations, the Court felt that the last of precision did not render his opinion speculative since “he stated the factual bases for his determinations based on his expertise, as set forth in his lengthy report and deposition.” Therefore, the Court concluded that substantial evidence supported the Appeals Board’s finding of apportionment.

Note: Applicant had degenerative disk disease in his cervical spine, but this pathology does not appear to have been a basis for the apportionment. Furthermore, this decision conflicts with *Martins v. WCAB*, (1995) 60 CCC 1151 in which the Court had stated that “it would be unfair to require an injured worker to cease all normal and necessary outside activities which could possibly aggravate an industrial injury in order to receive full compensation for that injury.”

Cross-reference

Anderson v. WCAB - Penalties/Labor Code §132a

Sierra Bible Church v. WCAB (Clink) (2007) 72 CCC 20, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant was evaluated by an AME for her industrial back injury. Relying on the AME's opinion, the WCJ found that 75 percent of the permanent disability was caused by nonindustrial factors. Applicant obtained new counsel and sought reconsideration of the apportionment finding. The Appeals Board reversed and awarded 77 percent permanent disability without apportionment. The defendant filed a Petition for Writ of Review.

The Court noted that in *E.L. Yeager Construction v. WCAB (Gatten)*, the Fourth Appellate District had recently reversed a unapportioned Award due to an employee's underlying chronic degenerative disease of the lumbar spine. However, *Gatten* could be distinguished in that the AME in the present case did not base his apportionment on medical evidence that Applicant *personally* suffered from an underlying pathology. Rather, he testified in his deposition that everyone after the age of 20 begins to suffer from degeneration of the discs in the spine, but as long as the disc remains intact, there are no symptoms. Otherwise, he concluded that the injury appeared to be work-related and that absent the injury itself, she would not have the symptomatology.

Finding this testimony to be "less than definitive on the issue of establishing apportionment," the Court held that the defendant had failed to carry its burden of proof and that Applicant was entitled to an unapportioned Award. Therefore, the Petition for Writ of Review was denied.

Marsh v. WCAB (2007) 72 CCC 336, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant sustained an industrial injury for which he was awarded 46 percent permanent disability. He petitioned to reopen his case for new and further disability. The WCJ found that his disability had increased to 70 percent, based on the opinion of an AME, and that there was no basis for apportionment. Ten days later, SB 899 was enacted. The case eventually came before the Court of Appeal which held that the new apportionment provisions were applicable to Applicant's petition to reopen. (*see Marsh v. WCAB* (2005) 70 CCC 787.)

The matter was remanded to the trial level and the AME was deposed after which the case was resubmitted. The WCJ again found no basis for apportionment, concluding that Defendant had not met its burden of proving that the AME's apportionment of 50 percent of the disability to pre-existing osteopenia (decalcified vertebrae) was substantial evidence. Defendant petitioned for reconsideration. The Appeals Board disagreed with the WCJ and found the AME's apportionment to be substantial evidence. However, it only apportioned half of the 24 percent increase in the permanent disability pursuant to its en banc decision in *Vargas v. Atascadero State Hospital* (2006) 71 CCC 500, which held that SB 899 apportionment applies only to the increased disability, and not to the overall disability. Thus, Applicant was awarded 58 percent permanent disability.

Applicant again filed a Petition for Writ of Review, contending that the apportionment was invalid because the AME was unable to determine Applicant's level of preexisting

disability to osteopenia with precision accuracy. However, the Court responded, the standard imposed by the Legislature was not a precise percentage, but rather an “approximate” one. The doctor explained that Applicant’s industrial compression fractures were caused by both the work exposure and the osteopenia, and that he would give 50 percent of his work restrictions to anyone with the same degree of pre-existing osteopenia in the absence of compression fractures. Although Applicant pointed to some inconsistencies in the AME’s testimony, the Court felt that overall, his opinion constituted substantial evidence. The writ was therefore denied.

Note: The Court approved of an apportionment based on retroactive prophylactic work restrictions that prior to SB 899 would not have constituted legal apportionment.

B. Labor Code §4664

Brodie, et al. v. WCAB (2007) 72 CCC 565, Supreme Court decision

In five consolidated cases, the Supreme Court addressed the following question: When a worker suffers an industrial injury that results in permanent disability, how should the compensation owed based on the current level of permanent disability be discounted for either previous industrial injury or nonindustrial disabilities? This question had previously been answered by the Supreme Court in 1976 in the case of *Fuentes v. WCAB* (1976) 41 CCC 42, in which the Court decided that prior disability should be apportioned by subtracting the prior percentage of disability from the current overall percentage of disability.

After SB 899 changed the standard for apportionment, the question arose of whether the new statutes still required subtraction of the percentage of disability. Some Courts of Appeal believed that the *Fuentes* decision was still good law, and that the prior percentage of disability should continue to be subtracted from the current percentage of disability. (Formula A) Others held that the new law required subtraction of the dollar value of the prior Award from the dollar value of the current disability rating. (Formula C) Since the permanent disability rating schedule is a graduated scale, application of Formula C would result in a much higher disability rating.

The Supreme Court decided that if the Legislature had intended to nullify the *Fuentes* decision, it would have said so. Thus, prior disabilities must be apportioned by subtracting percentages of permanent disability, and not the dollar values.

United States Fire Insurance Company v. WCAB (Urzua) (2007) 72 CCC 869, Court of Appeal, Second Appellate District, Division Eight, writ denied

Applicant was employed under the name Pedro Urzua when he sustained an admitted industrial back injury. Following the termination of his employment, he filed claims for two additional injuries. At his deposition, he testified that he had never been known by

any other name or used another Social Security number. He also confirmed that he had a prior industrial back injury, resulting in surgery, for which he received about \$27,000 by way of a settlement in approximately 1995. Subsequently, Applicant informed Defendant that he had used the name Adalberto Valencia and a different Social Security number in connection with his prior injury.

Applicant testified in his deposition and at trial that he terminated his employment because of pain from his injuries. The employer testified that he left because he was going to be transferred and did not wish to make the long commute. The WCJ found that Applicant sustained all three injuries and awarded benefits, including 63 percent permanent disability without apportionment.

Defendant petitioned for reconsideration, contending that Applicant was barred from recovery on the two claims that were filed after his termination, pursuant to the post-termination exclusion in Labor Code §3600(a)(10). Defendant further contended that Applicant failed to disclose all previous disabilities through willful suppression of medical reports, that Applicant's testimony was not credible, and that the reports of his treating physician did not constitute substantial evidence due to his failure to provide an adequate apportionment discussion.

In affirming the decision of the WCJ, the Appeals Board pointed out that from the language and structure of §3600(a)(10), it can be concluded that the legislative intent was to prevent employees and former employees from filing false claims in retaliation for being terminated or laid off and the statute did not apply to voluntary terminations.

Regarding the apportionment issue, the Board cited its en banc decision in *Pasquotto v. Hayward Lumber* (2006) 71 CCC 223, for the proposition that an Order Approving C & R is not an Award under Labor Code §4664. However, the medical reports generated in connection with the prior claim may be relevant in determining whether other factors caused the current disability. In any event, the burden is on the employer to prove overlap between the current and prior disability. Here, defendant presented no evidence of other factor aside from Applicant's deposition testimony that he had a prior injury that was settled.

Regarding defendant's claim that Applicant willfully suppressed evidence in the form of his prior medical reports, Defendant had the alias he used at the time of the prior injury for at least a year and a half prior to the trial and made no attempt to subpoena records from the prior attorney or employer, nor was there any evidence that Applicant was in possession of these documents. Therefore, Defendant failed to carry its burden of proving willful suppression and was likewise unable to prove overlap. Relying on the WCJ, the Board also rejected Defendant's arguments concerning the credibility of the Applicant and the evidentiary value of his doctor's reports.

Defendant filed a Petition for Writ of Review that was summarily denied.

XVI. Death Benefits**XVII. Hearings**

Sharareh v. WCAB (2007) 72 CCC 1371, Court of Appeal, First Appellate District, Divison Two.

Applicant asserted a claim for workers' compensation benefits, alleging his injuries sustained when he was shot in the throat were compensable under Labor Code § 3366, which provides benefits to an individual who is injured while assisting a peace officer at the officer's request. The matter proceeded to a hearing before an arbitrator who found that Applicant had not acted as an informant when he provided information about his assailant to a police officer and thus his injuries were not compensable because he was not assisting a peace officer at the time he was shot. Applicant petitioned for reconsideration, claiming that the arbitrator's failure to prepare a Summary of Evidence required reversal and that the arbitrator had incorrectly found that the circumstances of his injury didn't meet the requirements of §3366.

During the pendency of the reconsideration proceedings, Applicant died in an unrelated incident. The litigation was continued by his parents who were his sole heirs at law. The Board ultimately upheld the decision of the arbitrator, concluding the arbitrator had erred in failing to prepare a Summary of Evidence, but that Applicant had not been prejudiced by the error because he could not have prevailed even under his own statement of facts as set forth in his Petition for Reconsideration. Applicant's parents then sought judicial review.

The Court of Appeal disagreed with the Board's application of the "demurrer standard" which is designed to assess the adequacy *of a pleading*, rather than the lawfulness of a *final order, decision, or Award* of the Board. Instead of simply accepting as true all facts in Applicant's Petition for Reconsideration, the Court felt that the Board should have directed the arbitrator to prepare the requisite Summary of Evidence. The Court noted that in most cases, the WCJ's Summary of Evidence is the only unbiased overview of the testimonial evidence and, as such, is an essential component of meaningful judicial review. Without a comprehensive and unbiased summary of each witness's testimony, wthe Court was could not properly address the substantive issue raised in the Petition for Review—specifically, whether Applicant acted as an informant for a peace officer in connection with his injury.

The Court also rejected the application of the "statement of decision" standard which provides that a judgment must be reversed where a statement of decision does not explain the factual and legal basis for its decision on a principal controverted issue and the evidence is sufficient to sustain a finding in favor of the complaining party. Without a comprehensive Summary of Evidence, the Court could not assess whether the evidence was sufficient to support a finding in favor of Applicant.

The Defendants' invitation to apply a "substantial compliance" standard was similarly rejected because in the absence of a comprehensive Summary of Evidence, the Court could not assess whether the evidence was sufficient to support a finding in favor of Sharareh. The Court additionally found it to "troubling" that the arbitrator and Board placed undue emphasis on the fact that Applicant's motives were not entirely noble, a condition that cannot be gleaned from the wording of the statute.

Thus, the Board's order was annulled and the case remanded to the Board with directions to return the matter to the arbitrator for the preparation of a Summary of Evidence, and to thereafter prepare a new order consistent with the Court's opinion.

XVIII. Compromise and Release

XIX. Findings and Awards and Orders

XX. Reconsideration/Removal/WCJ Disqualification/Judicial Review

A. Reconsideration

Ramallah v. WCAB (McKinley) (2007) 72 CCC 772, Court of Appeal, Fifth Appellate District, unpublished opinion.

On August 15, 2006, the WCJ issued a decision awarding Applicant benefits and allocating liability between General and CIGA. Just above the WCJ's signature, the following appeared in boldface:

"A Petition for Reconsideration from this decision shall be filed only at the Fresno district office of the Workers' Compensation Appeals Board."

General filed a Petition for Reconsideration at the Fresno District Office on September 1, 2006. This petition was denied on October 31, 2006 but another petition filed by CIGA was granted in order to correct a clerical error in the allocation of liability between the defendants. This amendment resulted in a higher percentage of liability for General. The Appeals Board's decision did not appear on the face of the opinion, but are set forth in the California Code of Regulations.

On November 20, 2006, General filed a second Petition for Reconsideration alleging that the WCJ's decision was procured by fraud as evidenced by newly acquired *sub rosa* films. This petition was filed at the Fresno District Office and forwarded to the Appeals Board where it was filed on November 28, 2006. CIGA also filed a Petition for Reconsideration which was received by the Appeals Board on November 30, 2006. Both of these petitions were dismissed as untimely on January 22, 2007.

On February 6, 2007, General filed a third petition with the Appeals Board in San Francisco, stating it was aggrieved by the January 22, 2007 Opinion and Order. On April

9, 2007, the WCAB dismissed General's third Petition and described it as "an impermissible successive Petition for Reconsideration" of both the WCJ's initial August 15, 2006 determination and the Appeals Board's October 31, 2006 Decision After Reconsideration. The Board explained there was no legal basis for General to Petition for Reconsideration from its improperly filed second petition.

General sought judicial review, claiming that the reference in the third petition to the Board's October 31, 2006 decision was a "pleading error." General claimed that it was really requesting reconsideration of the WCJ's August 15, 2006 decision such that the petition would be properly filed at the Fresno District Office and thus timely. The Court noted that Assuming the veracity of this allegation, General did not present any legal authority permitting the filing of two successive petitions for reconsideration from a single WCJ decision.

General claimed that a Petition for Reconsideration based on fraud is not subject to the usual 25 days timeframe based on a Penal Code section governing the statute of limitations for felony insurance fraud. The Court found this statute to be inapplicable, however, commenting that Labor Code §5903 permits the Board to reconsider whether a workers' compensation order, decision, or Award was procured by fraud; and not whether an applicant should be convicted for a criminal offense. Since the second petition for reconsideration was not properly filed, there were no legal grounds to file the third petition, and the Petition for Writ of Review was denied. The Court also remanded the matter for supplemental attorney fees.

Nestlé Ice Cream Company, LLC v. WCAB (Ryerson) (2007) 72 CCC 13, Court of Appeal, First Appellate District, Division Two, unpublished opinion.

At Applicant's request, the WCJ issued an amended Award, correcting the names of the parties and increasing the amount awarded. Defendant filed a Petition for Reconsideration that was timely as to the amended Award, but not as to the original Award. The Appeals Board dismissed the petition as untimely.

The Court of Appeal held that when an Award is amended before a Petition for Reconsideration is filed, the time for seeking reconsideration runs from the date of the original order when the amendment is clerical in nature. However, when the amendment effects a substantial or material change in the Award or involves the exercise of a judicial function or judicial discretion, the time runs instead from the date of the amended order. In this case, the WCJ's amendment effected a substantial and material change in the Award and amounted to a judicial act, rather than the mere correction of a clerical error. Therefore, the Court annulled the Board's order dismissing the Petition for Reconsideration as untimely and remanded the matter for resolution on the merits.

Scott Pontiac v. WCAB (Olsen) (2007) 72 CCC 346, Court of Appeal, Second Appellate District, Division Eight, unpublished opinion.

Defendant filed a Petition for Reconsideration via a messenger service on the last day for filing. The messenger delivered the petition to the San Francisco District Office on the first floor instead of the Reconsideration Unit on the ninth floor of the same building. The Appeals Board did not receive the petition for seven days and dismissed it as untimely. Defendant sought judicial review.

Citing a number of similar cases, the Court of Appeal made the observation that “the Board prefers to decide cases on their merits whenever possible and especially when the error is of its own making . . . Simply because [the petition] had to be transferred from one floor to another in order to be in the right department should not result in a dismissal.” Accordingly, the Board’s decision was annulled.

XXI. Reopening

Phillips v. WCAB (2007) 72 CCC 406, Court of Appeal, Second Appellate District, Division Seven, unpublished opinion.

Applicant, an unrepresented injured worker, entered into a C & R of his 2001 injury that was approved by a WCJ on May 12, 2003. On or about November 19, 2004, Applicant filed a petition to reopen and set aside the C&R. He claimed that prior to the settlement he asked the claims adjuster to adjust the temporary disability indemnity paid, with the assistance of the Information and Assistance Officer, but the adjustment was never made. In November 2004, the adjuster requested tax information for 2000 and 2001, but then said to return to the information and assistance officer.

After a trial in which Applicant, the claims adjuster and the I & A Officer testified, the WCJ found no fraud on the part of the insurance carrier, and that the Order Approving C&R would remain in effect. Applicant petitioned for reconsideration, alleging he had been fraudulently misled into believing he would be paid additional temporary disability indemnity upon proof of correct earnings, after the C&R. The Appeals Board denied the petition, adopting and incorporating the report and recommendation of the WCJ.

The Court first reviewed the standards for finding good cause to reopen under Labor Code §5803. While reopening for good cause is not a means to re-litigate issues that should have been raised in a Petition for Reconsideration, or to present evidence that is simply cumulative or results in a mere change of opinion by the Appeals Board, the Court noted that under exceptional circumstances, there may be good cause to reopen even where there was a failure to Petition for Reconsideration.

The Court agreed that there was substantial evidence supporting the WCJ’s conclusion there was no fraudulent misrepresentation. However, there was evidence in the record that Applicant disputed earnings and the temporary disability rate, and that higher earnings documentation had been provided at the time the C&R was approved. Therefore, Applicant may have misunderstood the C&R and statements made by the claims adjuster together with the circumstances involving the I & A Officer contributed to that

misunderstanding. Consequently, the misunderstanding was excusable and the Court found “good cause” to reopen under §5803.

The Court also found additional good cause based on the fact that the WCJ and the I & A Officer discussed the I & A Officer’s proposed testimony prior to the trial; the lack of the I & A Officer’s notes in the WCAB file; and the fact that Applicant claimed he was never advised of the necessity of filing a Petition for Reconsideration for which there was no evidence to the contrary. Therefore, the matter was remanded for a determination of whether the C&R was adequate compensation or should be set aside in consideration of the earnings claimed by Applicant.

Wal-Mart Stores, Inc. v WCAB (Collier) (2007) 72 CCC 210, Court of Appeal, Fifth Appellate District, unpublished opinion.

The parties stipulated that Applicant was 100 percent disabled and entitled to further medical treatment. Four months after the Award issued, Defendant contacted a vocational counselor and requested an evaluation of Applicant’s employability. The counselor expressed the opinion that with recent improvements in voice activated software and good ergonomics in the work station, she might be able to work to a limited degree if the right job was created for her. A job description was provided to Defendant’s QME who checked off a box indicating that she was capable of performing it.

At the same time, Defendant’s UR physician, a chiropractor, denied a request for authorization of occupational therapy recommended by Applicant’s treating physician. Defendant filed a petition to reopen and Applicant filed a petition to enforce the medical Award. The WCJ denied Defendant’s petition and ordered Defendant to provide the medical treatment. Defendant petitioned for reconsideration which was denied by the Appeals Board. Defendant then sought judicial review.

In a scathing opinion, the Court of Appeal described Defendant’s contentions as “nothing more than a transparent third attempt to retract from its Stipulated Award and relitigate Applicant’s level of disability and need for further medical treatment.” It noted that Defendant presented no evidence that Applicant’s condition had improved but claimed that as a result of technology, the job market had improved. Furthermore, it failed to explain why this “evidence” was unavailable prior to the Stipulated Award.

Regarding the medical treatment dispute, Defendant had claimed that it was Applicant’s obligation to initiate the AME/QME procedure after she objected to the UR denial. However, the Court found that Defendant had the burden of demonstrating that care recommended by a treating physician was no longer appropriate. In any event, the failure of either party to obtain the opinion of an AME would not deprive the Appeals Board of the ability to enforce a prior Award of medical treatment on the basis of the existing evidence.

The Court denied the writ and found no reasonable basis for the petition.

Cross-reference

Gomez (Vicente) v. WCAB – See Jurisdiction and Venue

XXII. Statute of Limitations

County of San Bernardino v. WCAB (Schroeder) (2007) 72 CCC 1365, Court of Appeal, Fourth Appellate District, unpublished opinion.

Applicant worked for 30 years as a firefighter and later as a battalion chief. He last worked in 1999 and he filed for disability retirement in 2001. He had sustained a number of industrial injuries over the years. In 2002, he filed an Application claiming injury to his back, neck, and left knee as a result of continuous trauma over the course of his entire career. In 2003, he filed a timely Petition to Reopen a prior Award for left knee disability.

After the WCJ issued an Award, Defendant filed a Petition for Reconsideration which was denied except for an amendment of the date of injury of the cumulative trauma claim. Defendant then sought judicial review contending that the Board erred by not finding that the continuous trauma was barred by the statute of limitations and in concluding that all the cases should be rated together.

Regarding the Statute of Limitations, the Court of Appeal found that Defendant followed all applicable procedures and there was no basis in the record to find an estoppel. There was no evidence that Defendant had knowledge or notice of facts that would indicate an industrial cumulative trauma. Furthermore, Applicant was not an unsophisticated claimant and his own testimony revealed that he believed that his ongoing back problems were industrially caused. Therefore, since the claim was filed 2-1/2 years after the last date of work, it was barred by the Statute of Limitations.

The Board also erred in rating the various injuries together to produce a combined rating. The Court of Appeal has rejected application of the *Wilkinson* rule to situations where the injured employee has sustained successive, specific industrial injuries to different parts of the body which was the case here. Therefore, the Board's order was annulled on this basis as well, and the matter remanded for further proceedings consistent with this opinion.

Cross-reference

Fresno Unified School District v. WCAB (Butcher) – See Vocational Rehabilitation

Gomez (Maria) v. WCAB – See Vocational Rehabilitation

XXIII. Contribution**XXIV. Subrogation/Third Party Actions****XXV. Credit/Restitution/Fraud**Cross-reference

Gamble v. WCAB – See Vocational Rehabilitation

XXVI. Special Benefits**XXVII. Penalties/Sanctions/Contempt****A. Labor Code § 5814**

Mackey v. WCAB (2007) 72 CCC 365, Court of Appeal, Sixth Appellate District, writ denied.

Applicant sustained an injury in 1983. He filed his seventh petition for penalties and the issue was scheduled to be heard in 2001. However, the WCJ ordered the matter off calendar in the interest of judicial economy to be deferred until the trial of the balance of the issues. The case was ultimately heard in 2006 and the WCJ calculated the penalties in accordance with the post-SB 899 version of Labor Code §5814.

Applicant petitioned for reconsideration, contending that the WCJ denied him his due process rights by not calculating the penalty amount pursuant to the former § 5814, given that the penalty issue was originally set for trial in 2001. Finding that there was no exception to the current status, the WCJ recommended that the petition be denied and the Appeals Board adopted and incorporated his report. Applicant filed a Petition for Writ of Review that was denied without comment.

B. Labor Code §132a

Anderson v. WCAB (2007) 72 CCC 389, Court of Appeal, Second Appellate District, Division Six, published opinion.

Applicant claimed that his employer, a municipality, discriminated against him by forcing him to use vacation time rather than sick leave to obtain medical care for his admitted injuries. He also claimed that the AME's opinion did not constitute substantial evidence to support a finding of apportionment. Both the WCJ and the Appeals Board disagreed and Applicant filed a petition for writ review which was summarily denied. Applicant then sought review by the Supreme Court concerning the Labor Code § 132a issue only. The Supreme Court directed the Court of Appeal to vacate the summary denial and issue the writ of review.

Defendant's MOU contained a provision that "[t]his section shall not be construed to grant employees the use of sick leave benefits in lieu of or to supplement workers' compensation benefits provided herein or by State law." Defendant construed this to mean that injured workers were required to charge vacation time rather than sick leave for medical appointments. On the other hand, an employee who obtained medical treatment for a nonindustrial injury was allowed to change sick leave. The Court noted that Defendant could choose not to provide sick leave to any of its employees. But, if it does provide sick leave, it cannot refuse to permit its use for industrially-related medical appointments when non-industrially injured workers are not so restricted. It was found that such a policy contravenes Labor Code §132a and therefore Applicant was entitled to have his vacation time restored.

Regarding the apportionment issue, the Court upheld the Appeals Board in finding that the finding of apportionment was supported by substantial evidence.

Cross-reference

Anderson v. WCAB – See Apportionment

C. Serious and Willful Misconduct

Elk Grove Unified School District v. WCAB (Stroth) (2007) 72 CCC 399,
Court of Appeal, Third Appellate District, unpublished opinion.

Applicant, a fifth grade teacher, was injured when one of her students charged into her and knocked her down on the school bus. She claimed that her employer engaged in serious and willful misconduct by not permanently removing the student from her classroom, after she had had requested that he be removed. The WCJ agreed and the Appeals Board affirmed on reconsideration. The employer then petitioned for a writ of review, principally contending that the WCJ and the Appeals Board improperly applied a standard of negligence instead of serious and willful misconduct, and that the evidence did not show such misconduct.

The Court first noted that in the context of an alleged failure to act for employee safety, an employer guilty of serious and willful misconduct must (1) know of the dangerous condition, (2) know that the probable consequences of its continuance will involve injury to an employee, and (3) deliberately fail to take corrective action. After reviewing the evidence, the Court concluded that the student's long history of misconduct, acts of physical violence, and threats of violence toward Applicant satisfied the first two elements. However, it found that the third element had not been satisfied because the employer had taken corrective action on many occasions and the fact that such actions were not successful in preventing the injury was at most the result of negligence and not deliberate conduct. Thus, the Appeals Board's decision was annulled.

XXVII. Attorneys/Attorney Fees

Vierra v. WCAB (2007) 72 CCC 1128, Third Appellate District, published opinion.

Applicant, while unrepresented, entered into a Stipulated Award providing for 78 percent permanent disability. Subsequently, the defendant noticed his deposition. He then entered into a written “Agreement for Attorneys Fees” (the agreement) retaining counsel to represent him. Included in the agreement was the following language:

“...This agreement is an attempt to draft around the current policies under Labor Code [section] 4906[, subdivision (g)], which are believed to be outdated. The parties, accordingly, and pursuant to Labor Code [s]ection 4906[, subdivision (g)], and their constitutional right to enter into contractual relations, hereby agree that *the fee will be set at \$225 per hour to be paid out of permanent disability or 12% of the permanent disability award whichever is less.*” (Court of Appeal’s emphasis)

Counsel submitted the agreement to the WCJ who issued an order stating that the attorney fee agreement was not binding on Applicant. Thereafter, Defendant petitioned to reopen the case and reduce Applicant’s permanent disability. Applicant sought reconsideration of the WCJ’s order, contending the fee arrangement was appropriate and should have been allowed. The Appeals Board denied reconsideration reasoning that, since there was an available source of funds from which to petition for fees, Applicant was not yet aggrieved by the WCJ’s order. Applicant’s Petition for Writ of Review was granted.

Applicant argued that that, in the aftermath of legislative reforms slashing workers’ compensation benefits, a fee formula for \$225 per hour or 12 percent “satisfies any measurement of reasonableness.” And that the Appeals Board failed to comply with the law by simply rejecting the fee agreement “out of hand,” without evaluating its reasonableness. In response to this contention, the Court noted that attorney fees in workers’ compensation cases cannot exceed an amount that is “reasonable” and that the WCAB is the final arbiter of reasonableness in all cases.

While the law does not forbid contracts between applicants and attorneys, “approval” of a fee agreement can only come after services are rendered, and not before. Once services are rendered, the WCJ may approve, increase or reduce the fees provided for in the agreement, taking into consideration the factors listed in §4906(d), the applicable regulations and the Policy and Procedural Manual. Therefore, the WCJ’s conclusion that the fee agreement was not binding, was correct.

Smith/Amar v. WCAB (2007) 72 CCC 27, Court of Appeal, Second Appellate District, Division Six.

In *Smith*, Applicant received an Award for permanent partial disability and future medical treatment for his industrial injury to his right shoulder, neck and psyche. Eight years later, the carrier refused to furnish epidural injections for his back. Applicant

contacted the attorney who originally handled his workers' compensation case. He was examined by an agreed medical examiner who concluded that he needed the injections to relieve his back pain, which was precipitated by work-related injuries. Defendant then authorized the injections without a formal hearing.

In *Amar*, Defendant refused to pay for a weight loss program and treatment of Applicant's non-industrial diabetes. The diabetes treatment was found to be unnecessary, but the weight loss program was ordered to be reinstated.

In both cases, the WCJs found that the applicants did not establish the right to attorney fees pursuant to Labor Code §4607: in *Smith*, because the denial of care was not the result of a formal petition to terminate medical treatment, and in *Amar* because the defendant's conduct was not unreasonable. The applicants' petitions for reconsideration were denied and they sought judicial review.

The Court of Appeal rejected Defendant's argument that Labor Code §4607 should not be construed to authorize attorney fees because the statute, read literally, does not provide for them unless the attorney is opposing a formal petition to terminate care. It was felt that it made no sense to award attorney fees where all care is denied, but not to allow fees if only some of the treatment is denied. Similarly, it would be absurd to deny attorney fees simply because the carrier withdrew care without bothering to file a formal petition to do so. The Court held that Defendants who fail to provide previously awarded medical care may not avoid attorney fees to successful applicants' attorneys by an informal denial of care, even when they do so in good faith.

The Appeals Board's decisions were annulled and the matters remanded for the purpose of awarding attorney fees.

Note: The Supreme Court has granted review of the Smith decision such that the Court of Appeals decision has been automatically decertified and is not citable as precedent.
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XXIX. Civil Actions

Green v. State of California (2007) 72 CCC ____, Supreme Court. (filed August 23, 2007.)

In 1990, Plaintiff contracted hepatitis C, presumably in the course of his employment. He was not restricted nor did he lose time from work until 1997 when his physician began treating him with injections of the drug, interferon, three times a week. The treatment caused fatigue, aching and sleep difficulties. He requested and was granted light duty for a limited time period, and was allowed to arrive late on the days he received the injections. In June 1999, Plaintiff injured his back. He was again placed on light duty and subsequently, on disability leave.

In July 2000, plaintiff returned to work cleared for full duty. The employer's return to work coordinator reviewed his file and noticed a 1997 QME report that recommended plaintiff for light duty only. Based on this report, she concluded that Plaintiff should not have been cleared for full duty work because he was incapable of performing his duties. Plaintiff sought permission to return to work. Subsequently, his request to return to work was denied based on 1999 Findings & Award that found he had suffered a work-related injury.

Plaintiff filed a disability discrimination claim with the Department of Fair Employment and Housing. He also filed a complaint for damages in the Superior Court alleging that defendant discriminated against him because of his disability. The report of Defendant's QME was not allowed into evidence, nor was the doctor permitted to testify. The jury returned a general verdict for Plaintiff. The defendant appealed and The Court of Appeal affirmed the judgment in Plaintiff's favor.

The Supreme Court granted review and, in a 4-3 split decision, reversed the Court of Appeal. The Americans with Disabilities Act (ADA) requires that plaintiffs prove they are "qualified individuals" under the statute, i.e., that they have the ability to perform a job's essential duties, before they can prevail in a lawsuit for discrimination. The question presented was whether the Fair Employment and Housing Act (FEHA) includes a similar requirement, even though it does not expressly include the term "qualified individual." The Court of Appeal interpreted the FEHA's use of this phrase to mean that a plaintiff need not prove that he or she satisfies the ADA's "qualified individual" requirement, but that lack of qualification would be an affirmative defense

The Supreme Court majority noted that the FEHA prohibits discrimination against any person with a disability and, like the ADA, provides that the law allows the employer to discharge an employee with a physical disability when that employee is unable to perform the essential duties of the job even with reasonable accommodation. After reviewing the statute's language, legislative intent, and well-settled law, the Court concluded that the FEHA places the burden on employees to prove that they are qualified individuals under the statute just as the federal ADA requires, and not on employers to prove that they were not qualified. Therefore, the Court of Appeal's judgment was reversed and remanded.

In a lengthy dissent, the minority expressed the opinion that to place the burden on plaintiffs to prove their "qualifications" creates a presumption that is precisely what antidiscrimination laws were designed to combat. The legislative intent of the statute was to overcome the then widespread assumption that disabled people had no place in the workplace and the majority opinion effectively endorses this legally discredited assumption.

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