

California Update: Workers' Compensation Law



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Contains 2004 Updates

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Since 2004, and the enactment of SB899, the Workers Compensation system in California has gone through major changes. However, some of the basic aspects of Workers' Compensation are still applicable. California adopted its mandatory workers compensation system in 1913. It is a no fault system, meaning that injured employees need not prove that the injury was someone else's fault in order to receive workers compensation benefits for an on-the-job injury. This standard still applies to all claims of industrial injury in California.

The workers' compensation system is premised on a trade-off between employees and employers. Employees are supposed to promptly receive the limited statutory workers' compensation benefits for on-the-job injuries. In return, the limited workers' compensation benefits are the exclusive remedy for injured employees against their employer, even when the employer negligently caused the injury. The employer is not liable for general damages and is not subjected to a trial by jury.

This no-fault structure was designed to – and in fact did – eliminate the then prevalent litigation over whether employers were negligent in causing workers' injuries. Litigation is now over other issues, such as whether the injury was sustained on-the-job; how much in benefits an injured worker is entitled to receive, and what medical treatment is an injured worker entitled to within the guidelines set forth with the new legislation.

Industrial Injury: Any injury or disease, either mental or physical, arising out of employment and occurring during the scope of employment.

Compensable Injury: An industrial injury that results in 1) a need for medical treatment beyond first aid or 2) a disability that diminishes his or her ability to work. Note: The injury is compensable even if there is no disability. (*Western Growers 16 CA 4th 227*) If either of these criteria is met, the employer has an obligation to furnish monetary, medical, or other benefits.

AOE/COE REQUIREMENTS

Whenever there is a claim of a compensable industrial injury, the parties should analyze whether there is an issue as to whether the injury “arose out of the employment” and occurred during the “course of employment”. This is commonly referred to as AOE/COE.

“Arising out of employment” refers to the cause of the injury and the risks or hazards presented by the employment. The injury must appear to have its origin in a risk

connected with the employment and to have flowed from this risk as a rational consequence.

“**Course of Employment**” requires the Employee to be performing a service for the employer. This means generally that the employee is engaged in acts within the scope of the employee's duties, in accordance with the employer's instructions. (Hanna 4.03)

The liberal interpretation requirements of **Labor Code 3202** apply to this analysis. The Courts are and the cases have established a clear policy of including claims in the worker's compensation system by finding them to be compensable.

EXCLUSIONS TO COVERAGE/WHERE AOE/COE WILL NOT APPLY

Labor Code §3600 still delineates the exclusions of coverage and where AOE/COE will not apply.

One of the most recent decisions on the issue of injury AOE/COE:

Tomlin v. WCAB (2008) 73 CCC 593, Court of Appeal, Second Appellate District, Division Five:

Applicant was a police officer assigned to the SWAT team. Part of his job requirement was to pass an annual physical fitness test. Part of his compensation was being paid to train four days each month. In addition, the employer sent the Applicant to train out of state. In order to maintain his physical fitness, Applicant participated in running, biking and weight lifting. He did these activities with other SWAT team members outside of work for which he was not paid. In addition to training with other SWAT team members, he also ran while he was on vacation to maintain his fitness. His annual test was set in January 2006. For this test, Applicant began a course of fitness training which was to continue through his two week vacation in December of 2005. During December 2005, while on vacation in Wyoming, he went for a three-mile run, slipped, and broke his left ankle. He was unable to take the January 2006 physical fitness exam. However, he did take and pass a subsequent test.

Initially, Defendant denied Applicant's claim for worker's compensation stating that the injury occurred while he was voluntarily participating in an off-duty recreational or athletic activity. The WCJ agreed with defendant basing the decision on the fact that Applicant's belief that the employer expected him to jog during his vacation was not objectively reasonable. Applicant petitioned for reconsideration. The WCAB adopted the WJC's report denying reconsideration. Applicant filed a petition for writ of review, which was granted.

The Court of Appeal in its opinion noted that Labor Code §3600 excludes injuries arising out of voluntary participation in off-duty recreational, social, or athletic activities unless those activities are a reasonable expectancy of the employment. Per *Ezzy v WCAB* (1983)

48 CCC 611, the reasonable expectancy test consists of two elements: 1) whether the employee subjectively believes his or her participation in an activity is expected by the employer, and (2) whether that belief is objectively reasonable. In this case, the Applicant had testified that he believed he was expected to train. This testimony was never rebutted. Therefore, only the second prong of the *Ezzy* test was at issue.

The Court reasoned that since part of the Applicant's employment was to be fit and to pass annual mandatory fitness tests, physical fitness training, whether undertaken during vacation or not, was a reasonable expectancy of the employment. To cease training while on vacation would be inconsistent with the employer's requirement that Applicant remain fit enough to pass the physical fitness test. Thus, the injury was compensable.

The Court annulled the WCAB's decision and remanded the matter for further proceedings consistent with its opinion.

PRESUMPTION OF COMPENSABILITY

A new Panel Decision has been issued as of May 27, 2011 addressing the Presumption of Compensability as it relates to Labor Code §3212.1 which relates to the Cancer Presumption for active firefighters and peace officers. In general, LC §3212.1 states that while a firefighter or peace officer develops or manifests cancer during a period in which the member is in the service of the department or unit, if the member demonstrates that he or she was exposed to a known carcinogen, the member has an industrial injury. In this newest Panel Decision, *Jackie Thompson v. Los Angeles Unified School District* 2011 Cal. Wrk. Comp. P.D. LEXIS 249, it was determined that Applicant was not entitled to the presumption of compensability wherein her peace officer authority was defined by Penal Code §830.32, not Penal Code §830.1. The difference in these sections being that Penal Code §830.1 defines the authority of peace officers whose authority "extends to any place in the state", but Penal Code §830.32 limits the authority of the peace officers to school district employees. The WCJ felt that the Legislature did not include Penal Code §830.32 within the Labor Code and therefore the intent was to not include such employees under this presumption.

STATUTE OF LIMITATIONS

An application for Adjudication of Claims, which is the pleading filed with the Workers Compensation Appeals Board must be filed within 1 year of the later of 1) the date of the injury, 2) the date of the last indemnity payment for temporary or permanent disability or 3) the date of the last furnishing of any medical or hospital benefits. (LC 5405) The Appeals Board has held that the one year does not start to run until the denial of medical benefits so an application 9 years after the date of injury was timely even though no

medical was furnished within 5 years when the application filed within one year of denial of medical treatment. (*Viking Freight Systems v. WCAB* 62 Cal Comp Cases 123)

Following are some of the most recent decisions regarding Statute of Limitations.

***City of Santa Ana v. WCAB* (2008) 73 CCC 460, Court of Appeal, Fourth Appellate District, Division Two, UNPUBLISHED OPINION.**

Applicant filed a cumulative trauma to his heart fourteen years after his retirement. He further amended the claim to include his skin and prostate cancer. Defendants raised a statute of limitations defense which was denied by the WCJ. The claim was found compensable as the WJC determined that there was no evidence that the Applicant was ever aware of his injuries prior to the filing of the claim. Defendant's petition for reconsideration was denied and they sought judicial review.

Defendants claimed that the Applicant's claim was barred pursuant to Labor Code §§5402 and 5412. In addition, the Defendants alleged that substantial evidence did not support the finding that Applicant's prostate cancer was industrially caused. Citing Labor Code §5412, the Court stated that the date of injury in cumulative trauma cases is that date upon which the employee first suffered disability and either knew, or in the exercise of reasonable diligence should have known, that the disability was caused by his employment. Although Applicant began experiencing chest pains in the early 1990's and even had a stress echocardiogram in 1992, it was not until 2003 that he was diagnosed with coronary heart disease. Thus, his claim filed a few months later was not time barred.

As it relates to the skin cancer, the Applicant had testified that no one had ever told him his skin cancer was related to employment prior to filing his claim. However, even assuming this to be true, the Court found that he knew or reasonably should have known of the connection. In addition, Applicant had a 30-year history of skin problems due to sun exposure. Applicant also had been receiving medical treatment and advice during this time. The Court felt that the Applicant should have known the connection to the sun exposure and his skin problems due to the active treatment and the preventative measures he had taken. Therefore the Court found that Defendant did establish the statute of limitations defense with regards to Applicant's skin cancer claim.

However, as it relates to Applicant's prostate cancer, Applicant's QME had determined cited studies linking the connection of cadmium exposure and an increase risk of prostate cancer. In addition, Applicant had sufficiently established that he was exposed to cadmium in his employment. The Court found that the opinion of the QME could not be dismissed as based on surmise, speculation or conjecture and the Board was entitled to rely on this medical evidence. The Board's order was annulled and the matter was remanded for further proceedings consistent with the Court's opinion.

CIGA v. WCAB (Carls) (2008) 73 CCC 771, Court of Appeal, Second Appellate District, Division Four

In 1996, Applicant suffered an industrial injury wherein he filed a workers' compensation claim. This claim was accepted and TTD benefits were administered. In 1997, he suffered another injury, this one to his back. This injury occurred after arriving at work two hours early. He again reported his injury, but this time the employer neither advised him of his potential rights for worker's compensation nor did they provide him with a claim form. In approximately 1999, Applicant retained an attorney. The attorney proceeded to file an Application of Adjudication for the 1996 claim but did not file an Application for the 1997 claim. In August 2002, the 1996 claim was set for trial, but the WCJ took the matter off calendar to allow the Applicant to file his claim for the 1997 date of injury. Applicant did not file his Application for the 1997 date of injury until March 2004. CIGA raised the one-year statute of limitations as a defense.

In 2004, the two matters were consolidated and went to trial. Applicant's testimony consisted of the fact that when he had injured his back in 1997 he reported the incident to his supervisor and the worker's compensation manager. However, he was not given a claim form. He was also given a difficult time due to the fact that he had arrived early to work. Because of this, he proceeded to treat with his own doctor. At no time did the employer advise him of his right to file a worker's compensation claim for this back injury. In addition to the testimony, the AME report from 2001 stated that the Applicant had injured his back in 1997 and reported it to his employer. On the signature page of this report it was noted a copy of the report went to Applicant's Attorney. As early as 1999, the treating physician sent a report to counsel in which he detailed the 1997 injury.

The WCJ found the claim was not barred by the statute of limitations, but vacated this decision when CIGA filed a petition for reconsideration. The Board rescinded the F&A as it was determined the record to be inadequate to allow meaningful review. The WCJ again rejected the statute of limitations defense CIGA raised as the WCJ determined the statute was void by the failure of the employer, insurer, or CIGA to notify the Applicant of his right to claim benefits. The WCJ also concluded that CIGA was stopped from asserting the statute of limitations by its failure to admit coverage for the 1997 injury until May 2003 which delayed the filing of the Application by the Applicant. The WCAB denied CIGA's petition for reconsideration and a petition for writ of review was filed by CIGA.

The Court noted that the burden was on CIGA to prove when the Applicant gained actual knowledge of his workers' compensation rights, and to carry its burden, CIGA was required to overcome a rebuttable presumption that Applicant was ignorant of those rights. The Court determined that there was no substantial evidence that Applicant was actually aware that the 1997 injury was potentially compensable as an industrial injury since it was sustained prior to the commencement of his shift. Although Applicant's Attorney requested time to file an Application regarding the 1997 injury at the trial in 2002, this did not demonstrate actual knowledge on the part of the Applicant, rather it only showed Applicant counsel's belief that there might have been a

compensable injury. In addition the hiring of counsel for the previous injury did not establish actual knowledge either. The Attorney's knowledge cannot be imputed to the client. Nor did the content of the medical reports show the Applicant's actual knowledge as there was no evidence showing that the Applicant read these reports.

Finally, the Court noted that the party challenging the sufficiency of the evidence must raise any specific deficiencies in its petition for reconsideration. CIGA failed to raise these issues in their petition. Therefore, the decision of the Board was affirmed.

Reynolds v. WCAB (1974) 39 CCC 182

This case is still significant and has been recently cited in a couple of Panel Decisions. In the *Reynolds* case, the Supreme Court held that because the employer was obligated to give certain notices prescribed by the administrative rules and the employer failed to do so, the employer was not allowed to raise the technical defense of the statute of limitations to defeat petitioner's claim.

Pugh v. WCAB (2008) 73 CCC 1561, Court of Appeal, Second Appellate District, Division One, UNPUBLISHED OPINION

In this case, the Court noted that pursuant to Labor Code §3550, every employer subject to the workers' compensation law is required to post a notice advising employees of their rights under that law. The notice must be posted "in a conspicuous location frequented by employees" and must include the existence of time limits for the employer to be notified of an occupational injury. In this case, the Applicant had been treating with her primary physician for work-related stress, but did not file her Application for Adjudication until August 2003. However, she testified that she never saw any signs posted at the facility where she worked advising her of her rights. Defendants produced no evidence to the contrary. The Court cited the *Reynolds* case and stated that the Supreme Court had held that because the employer was obligated to give certain notices prescribed by the administrative rules and failed to do so, it was not allowed to raise the technical defense of the statute of limitations. The Court pointed out that these required notices informs the employees that "worker's compensation covers most work-related injuries physical or mental injuries and illnesses and that the employee should report her injury immediately because there are time limits and if you wait too long you may lose your right to benefits. The Appeal Board's decision was annulled and the case remanded for further proceedings consistent with the Court's opinion.

Gloria Vanover-Lopez v. Kelly Staff Leasing, PSI, 2011 Cal. Wrk. Comp. P.D. LEXIS 301 (Panel Decision)

This case shows a trend wherein the Defendants failure to provide an Applicant all required notices regarding his or her rights is no longer sufficient, in itself, to estop a defendant from raising statute of limitations as a defense, and that the WCJ in making his

decision, should consider whether the Applicant was prejudiced by Defendant's apparent breach of notice requirements and whether the Defendant should be estopped from relying upon LC §5405 statute of limitations.

DECISION TO ACCEPT OR DENY CLAIM

Often times the employer or the claims adjuster needs to conduct an investigation prior to accepting or denying the claim. This may include interviewing witnesses, co-employees, obtaining medical records and having a medical evaluation. If there is a good faith need to investigate the claim prior to accepting it, a Notice of Delay must be served upon the employee. The employer has a maximum of 90 days to accept or reject the claim. The 90 day period commences when the employee files the claim form. However, employer knowledge may trigger presumption that claim has been accepted if rejection is not made within 90 days *Paula Ins. v. WCAB* (1995) 60 CCC 356; LC §5402(a)

During this period of investigation, the employer shall authorize the provision of all treatment, consistent with LC§5307.27 or the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, for the alleged injury and shall continue to provide the treatment until the date the liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars (\$10,000.00) LC§5402(c).

If the claim is not rejected within 90 days after the claim form is filed with the employer under Section 5401, the injury **shall** be presumed compensable. The presumption is rebuttable only by evidence discovered subsequent to the 90-day period. If the employer has notice of a potential injury and fails to do anything about it or fails to give the insurance carrier notice, the time period will pass and the claim will be presumed compensable. As a practical matter, it is almost impossible to rebut the presumption with evidence that was discovered after the 90 days. LC §5402 (b).

EMPLOYER'S RIGHT TO CONTROL TREATMENT

On or after January 1, 2005, an insurer or employer may establish or modify a medical provider network for the provision of medical treatment to injured employees. If the insurer or employer has a proper Medical Provider Network (MPN) in place at the time of injury and the injured worker has not pre-designated a treating physician, the injured worker must treat within the insurer/employer's MPN. At any time the injured worker can change his primary treating physician as long as it is within the MPN. This is assuming the MPN is a valid MPN that has been properly submitted to the Administrative Director and approved by the Administrative Director. In addition, this is assuming that all proper notices have been given to the employees regarding the MPN.

The following are some of the most recent decisions regarding the Medical Provider Networks.

***Valdez v. Warehouse Demo Services* (2011) 76 CCC 970; 2011 Cal Wrk. Comp. LEXIS 145 (1st En Banc Opinion filed on 4/20/11; 2nd En Banc Opinion filed 9/27/11) It should be noted that the 2nd En Banc Opinion basically re-affirmed the original en banc decision.**

On October 7, 2009, Applicant Elayne Valdez slipped and fell at work. She injured her back, right hip and neck. This was an accepted claim and Applicant started treatment with her employer's MPN for three weeks. After retaining counsel and upon counsel's advice, Applicant began to treat outside of her employer's MPN.

The new treating physician found Applicant TTD, however, the insurer refused to pay and the case was set for an Expedited Hearing on the issue of TTD on July 22, 2010. The WCJ found in favor of the Applicant relying on the reports of the non-MPN PTP's reports. The WCJ deferred the issue raised by the Defendant as not relevant to TTD issues.

The WCAB granted Defendant's Petition for Reconsideration and on April 20, 2011, the WCAB issued an en banc decision holding that if an employer's MPN is valid, the injured worker must select a PTP from within the MPN. If the IW chooses to select and treat with a PTP outside the *valid* MPN, then any non-MPN medical treatment reports will be deemed inadmissible as evidence and the Defendant will not be held liable for their costs.

In this case, the WCAB was clear in their analysis regarding MPN's. As long as there is a valid MPN, the injured worker SHALL select a PTP from the MPN. (LC§4616.3(b)).

The WCAB went on to discuss that if the MPN was not valid for any reason, or if the employer did not provide the Applicant with the mandatory MPN notices, then the Applicant might be exempt from the requirement that she choose a PTP from the employer's MPN. This was in accordance from the previous findings under *Knight v. United Parcel Service* (2006) 71 CCC 1423 (WCAB en banc).

The WCAB then went on to delineate how to resolve the issue of medical treatment. It is clear that in accordance with LC§4616.3(c), if the injured worker disputes the PTP's diagnosis or prescribed treatment, the remedy is to select another MPN PTP or seek a second or third opinion from within the MPN. If there continues to be a dispute after the 3rd opinion, the dispute will be resolved by an Independent Medical Reviewer inside the MPN. In addition, the WCAB emphasized that non-MPN medical reports shall NOT "be admissible to resolve any controversy arising out of this article." (LC§4616.6).

As it related to Ms. Valdez and whether or not she was entitled to TTD pursuant to her non-MPN doctor, the WCAB emphasized LC§4061.5 and 8 CCR 9785(b)(3) which state that if the injured worker disputes a medical determination made by the PTP..., the dispute shall be resolved under the applicable procedures set forth at Labor Code sections 4061 and 4062. These sections refer to the AME/QME process and procedures. In addition as it relates to this claim, the AME/QME sections are triggered by a party's objection to the PTP's report. And the ONLY ELIGIBLE PTP that a party could object to would be one selected by the injured worker from the employer's valid MPN. In this case, the WCAB held that the injured worker violated LC§4616 by securing a PTP outside of her employer's MPN. Therefore the reports from her non-MPN PTP were deemed NOT admissible into evidence at trial and the finding of TD in favor of the injured worker by the WCJ was overturned.

PLEASE NOTE: There were two dissents from the majority in this case. The dissenting commissioners were troubled by the all-inclusive ruling that barred the use of non-MPN medical reports from ALL cases dealing with valid MPN's regardless of circumstances. These commissioners felt that this determination was in direct conflict with two LC Sections that seem to allow ALL PTP reports; LC§4605 states that "Nothing contained in this chapter shall limit the right of the employee to provide, at his own expense, a consulting physician or any attending physician whom he desires." In addition LC§5703(a) sets forth what the WCAB may accept as admissible evidence, specifically reports of attending or examining physicians.

Applicant has filed a Write of Review in this matter on 11/10/2011 with the 2nd DCA. To date, it appears that the DCA had not yet granted or denied the Petition for Writ.

Ana Lilia Rodriguez, Applicant v. Country Villa Health Services, Zurich American Insurance Co. administered by Tristar Risk Management, Defendants, 2011 Cal. Wrk. Comp. LEXIS 242 (Panel Decision)

This case cites the *Valdez* case in support of the findings that reports from non-MPN physicians were inadmissible and could not be relied upon, and Defendant was NOT liable for cost of such reports. In this case, the Defendant again had a validly established and properly noticed MPN.

There are certain requirements that an employer must follow in order to establish a valid MPN, including proper notice to the employees. LC§4616 and 8 CCR 9767.1 outline such procedures. The following are some recent decisions discussing the Notice Requirements.

Carmen Rodriguez, Applicant v. Pea Soup Andersen's Best Western, State Compensation Insurance Fund, Defendants. 2011 Cal. Wrk. Comp. P.D. LEXIS 297

In this case, the Applicant suffered an industrial injury on 12/13/1996 to her left elbow, left shoulder, right knee and cardiovascular system (hypertension). The WCJ held that the Defendant had made adequate attempts to provide medical treatment for the injured worker. The WCAB rescinded this decision and remanded the matter back to the trial level. Here, the WCAB cited *Knight v. United Parcel Service* (2006) 71 CCC 1423 (WCAB en banc) and held that an employer has an affirmative duty to find a treating physician to treat an injured worker. The Defendant had no physician within the employer's MPN within a reasonable geographic area that was willing to treat worker. In addition, when worker's own reasonable efforts failed to produce a physician willing to treat, the Defendant has provided a defective MPN list in that all providers on the list refused to treat Applicant. Therefore, the Applicant was free to continue treatment outside the MPN at Defendant's expense, as Defendant was unable to find a treating physician to treat Applicant. The WCAB also instructed the parties to work together to resolve the medical treatment issue expeditiously, noting that in smaller communities there may be limited treating doctors available to treat injured workers.

Clemente Quintero, Applicant v. Adecco PSI, c/o Broadspire, Defendants 2011 Cal. Wrk. Comp. P.D. LEXIS 291 (Panel Decision)

Here, the WCAB affirmed the WCJ determination which held that the Applicant was required to treat within Defendant's MPN. The WCAB found that the Defendant had complied with MPN notice requirements set forth in 8 CCCR §9767.12(a) based upon information in the Employee Handbook. The Applicant acknowledged receipt of the handbook. In this case, the WCAB found that 8 CCR§9767.9 did not apply because Applicant's injury was accepted and initial treatment was within the MPN. In addition, even if it had been determined that Defendant did not strictly comply with notice requirements, Applicant would not have been permitted to treat outside the MPN pursuant to the *Knight* case as the Applicant had not showed that Defendant's failure to provide adequate notices resulted in a neglect or refusal to provide reasonable medical treatment.

Judith Vandenheuvel, Applicant v. K-mart Corporation, PSI, Administered by Sedgwick Claims Management, Defendants 2011 Cal. Wrk. Comp. P.D. LEXIS 255 (Panel Decision)

Applicant suffered injury to her lungs and psyche on 3/1/1998 on an industrial basis. She was treating with her long-time non-MPN treater. The WCJ had determined that Applicant was entitled to continue to this treatment. The WCAB affirmed the WCJ's findings as they had determined that the Defendant's did not adequately comply with notice requirements in 8 CCR §9767.9 for transfer of care into the MPN. The WCAB also determined that Applicant could continue to treat with her outside physician up to one year after proper notice was provided by Defendant pursuant to 8 CCR§9767.9(b)-(j) regarding transfer of care.

Eddie Espinoza, Applicant v. Barrett Business Services, Inc., PSI, Defendant
2011 Cal. Wrk. Comp. P.D. LEXIS 212 (Panel Decision)

In this matter, the WCAB rescinded the WCJ's determination that Applicant was entitled to treat outside of Defendant's MPN and that the reports generated by the non-MPN physician were admissible into evidence based upon Defendant's failure to provide proper MPN notices. Here, the WCAB remanded the matter back to the WCJ to evaluate whether Defendants inadequate notices resulted "in a neglect or refusal to provide reasonable medical treatment" pursuant to *Knight v. United Parcel Service* (2006) 71 CCC 1423 (WCAB en banc) In addition, the WCJ was determine whether absent proof of these initial notices, Defendant had regained control over the Applicant's medical treatment based upon subsequent compliance with the notice requirement as set forth in *Babbitt v. Ow Jing dba National Market* (2007) 72 Cal. Comp. Cases 70 (Appeals Board en banc opinion)

MEDICAL TREATMENT

For injuries occurring on or after January 1, 2003, the Primary Treating Physician does not have a Presumption of Correctness unless the Primary Treater was also the pre-designated physician.

The reporting requirements for the primary treating physician are set out in 8 CCR 9785. Within 5 working days following the initial examination, the primary treater shall submit a written report to the claims administrator on the form entitled "Doctor's First Report of Occupational Injury of Illness". The Report must include the methods, frequency and duration of planned treatment, planned consultations or referrals, surgery or hospitalization and specify the type, frequency and duration of planned physical medicine services such as physical therapy, manipulation or acupuncture. Each new primary treater must complete a Doctor's First Report.

The primary treater is required to prepare and serve a progress report no later than forty five days from the last report. If there is any significant change in the treatment plan, the primary treater should not wait for the 45 day period to provide a progress report. Such a change mandates the prompt issuance of a progress report. A significant change includes an extension of duration or frequency of treatment, a new need for hospitalization or surgery, a new need for referral to or consultation by another physician, a change in methods of treatment or in required physical medicine services or a need for rental or purchase of durable medical equipment or orthotic devices. (8 CCR 9875 (f)) In addition, the primary treater shall obtain and comment on all of the reports of secondary physicians and shall incorporate, or comment upon, the opinions of the other physicians and submit these secondary reports to the claims administrator.

Pursuant to LC§5307.27, the Administrative Director adopted a medical treatment utilization schedule that incorporated the evidence-based, peer-reviewed, nationally

recognized standards of care recommended by the commission. This standard set forth the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers' compensation cases. Medical requests made by the PTP are now put through the Utilization Review process. All medical treatment must be pursuant to the ACOEM Guidelines. If the injury is one where the ACOEM guidelines or the official utilization schedule are not covered, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines that are recognized generally by the national medical community and scientifically based. LC§4604.5(e) An Applicant is entitled to all medical treatment necessary to cure or relieve the effects of the injury. However, the treatment must still be in accordance with the guidelines and all requests can go through the Utilization Review process.

When a medical request from the injured worker's PTP or secondary treater has been submitted through the Utilization Review process and the treatment has been denied, the injured worker can still find recourse through the worker's compensation system.

The following are the most recent decisions regarding Medical Treatment and/or Utilization Review.

***Jackie Plaskett, Applicant v. Safeway, Inc., PSI, Defendant* 2011 Cal. Wrk. Comp. P.D. LEXIS 240 (Panel Decision)**

The UR doctor had denied Applicant's request for medical treatment in the form of aqua therapy. The WCJ determined that the Applicant was entitled to the aqua therapy to cure or relieve the effects of her cumulative injury to her neck and low back. The WCAB upheld the WCJ's findings which were based upon the findings of the PTP and AME and that, although the Medical Treatment Utilization Schedule (MTUS) is presumptively correct, there is no presumption that the UR doctor had properly applied or interpreted the MTUS so as to compel the WCJ to follow his determination.

***Pamela Hunt, Applicant v. Sutter Maternity and Surgery Center, State Compensation Insurance Fund, Defendants* 2011 Cal. Wrk. Comp. P.D. LEXIS 277 (Panel Decision)**

Applicant had a history of chronic severe pain following industrial ankle and knee injuries. Defendant denied medical treatment, including various narcotic pain medications prescribed by Applicant's treating psychiatrist for her chronic pain. The WCAB affirmed the WCJ's decision ordering Defendant to authorize such treatment. Applicant had had a favorable response to a multidisciplinary pain treatment program, which included psychiatric treatment and narcotic medications, thus supporting the need for prescription medications recommended by the treating psychiatrist. In addition the California Chronic Pain Medical Treatment Guidelines regarding opioid use for chronic pain as relied on by Defendant did not apply because opioid guidelines are expressly limited to situations where a patient has not yet commenced a trial of opioid medications. In addition Defendant's contentions that narcotic medications were not appropriate

because the prescribing doctor did not follow guideline for opioid use, document function, prepare an opiate contract, conduct random drug screening, or provide evidence that amount of opiates was effective for Applicant's reported pain was not supported by evidence in the record. Additionally, Defendant's contention that the narcotic opioid use was not supported by evidence in the record or by chronic pain medical treatment guideline was rejected. Finally, Defendant did not establish that medications prescribed by the psychiatrist were inappropriate or contrary to MTUS guidelines.

***Roscoe Walker, Applicant v. B&G Heat & Air, State Compensation Insurance Fund, Defendants* 2011 Cal. Wrk. Comp. P.D. LEXIS 302 (Panel Decision)**

There was no dispute that Applicant was found permanently totally disabled as a result of cognitive and behavioral impairments resulting from a 9/2/2005 automobile accident. Due to this level of impairment, it was determined that Applicant could no longer live in her home. There was substantial evidence indicating that Applicant's current home was unsafe given Applicant's disability. It was also determined that the current home could not be made safe even if modified for ADA compliance. The WCJ found that Applicant was entitled to a new home. The WCAB affirmed the WCJ's findings. The WCAB also found that a rental home would be inadequate to provide a stable living situation due to the possibility of the sale of the rental property. The WCAB found that the Defendants were liable for the amount that it would cost to remodel the existing home in addition to the amount of the mortgage in excess of mortgage paid for the existing home with a credit to the Defendant for proceeds Applicant obtained from the sale of the present home.

***Willis v. Waste Management* 2011 39 CWCR 263 (Panel Decision)**

Applicant's PTP requested authorization to perform a right knee arthroscopy and chondroplasty and authorization for 12 postoperative physical therapy sessions. UR denied such request in a timely fashion. Applicant immediately filed for an Expedited Hearing on this issue without seeking either an AME or engaging in the Panel QME process pursuant to LC§4062(c) to resolve the UR dispute. The WCJ ordered the treatment rejecting the UR recommendation. Defendants sought removal of the decision arguing that LC§§4610 and 4062 require that the Applicant seek either an AME agreement or obtain a three-panel QME prior to seeking a hearing to resolve the dispute. The WCAB granted the removal and reversed the WCJ determination. The Board relied on its prior decision in *Willet v. Au Electric Corporation* (2004) 69 CCC 1298 wherein it was determined that it is a requirement for the injured worker to first object to the UR determination and then utilize the AME/QME process as provided by LC§4062 before proceeding to a hearing. This decision reinforces the concept that the language in LC§§4062 and 4610 is mandatory and not discretionary.

TEMPORARY TOTAL DISABILITY

Disability payments are a substitute for lost wages during a period of temporary incapacity from working. (*Herrera v. Workmen's Comp App. Bd.* (1969) 71 Cal 2d 254. If an injury causes temporary disability, the disability payment is two-thirds of the average weekly earnings during the period of such disability, consideration being given to the ability of the injured employee to compete in an open labor market. LC§4653

Pursuant LC§4656(c)(1)&(2), Aggregate TTD payments for a single injury occurring on or after April 19, 2004, causing temporary disability shall not extend for more than 104 compensable weeks within a period of 2 years from the date of commencement of TD payment. Aggregate disability payments for a single injury occurring on or after January 1, 2008, causing TD shall not extend for more than 104 compensable weeks within a period of five years from the date of injury.

Please note that the Labor Code gives specific instructions for carved out injuries or conditions under LC§4656.

The following are the most recent decisions regarding TTD benefits.

***Jesus Rebolar, Applicant v. Specialty Restaurants, Zurich North America, Defendants* 2011 Cal. Wrk. Comp. P.D. LEXIS 293 (Panel Decision)**

Applicant received EDD benefits for his industrial injury of 5/6/2008 to his right wrist and psyche. The WCJ held that the EDD benefits were outside the cap set in LC§4656(c)(2). The WCAB reversed this determination finding that EDD benefits, to the extent they are reimbursed by Defendant, constitute TD benefits, as they serve the same purpose as TD indemnity, i.e., to replace wages lost by the injured worker during period of disability.

***Motheral v. WCAB* (2011) 76 Cal Comp Cases 720, Court of Appeal, Third Appellate Division**

In order to properly determine average weekly wages, the Defendant must take into consideration the value of the employer provided housing as well as the value of the car allowance. When determining the value of the housing, the WCJ erred in using the value outlined in the employment contract which was artificially low and the fair market value of housing was the appropriate amount as outlined in LC§4454. The WCAB had affirmed the findings of the WCJ and Applicant filed a Writ of Review. LC§4454 states in part that “there shall be included overtime and the market value of board, lodging, fuel, and other advantages received by the injured employee as a part of his remuneration, which can be estimated in money.”

Here, the Applicant was a residential camp ranger by the Boy Scouts of America. He was paid at minimum wage with an offset of \$5,055 per year for the use of the living quarters at the camp. The Court found that there was no doubt that the lodging and utilities were provided to the Applicant as remuneration for his services. The Court

noted that there are regulatory limits on the amount of offset an employer can take against minimum wage earning for the provision of meals and housing. These amounts override whatever may have been the Applicant's employment contract. At the time of the contract, the limit was \$423.51 per month and any amount in excess of the deductions taken in the specified deduction was an advantage to the Applicant which must be calculated in the Average Weekly earnings calculations. Since the lodging was provided in exchange for his services the employee is entitled to have the value of that housing included in the calculation of his TTD rate.

SEASONAL WORKERS: Entitled to benefits based upon earnings at the time of injury only for the period that the worker's employment would have lasted, that is, to the end of the season. After that, only entitled to benefits based upon past earnings history and anticipated future earnings had the worker not been injured. However, if there is no evidence of available work when the season ends, there is no requirement for temporary disability payment (*Arroyo v. WCAB 1997 62 Cal Comp. Cases 653*)

TEMPORARY WORKERS: If an employee is hired for a temporary period of time and has an industrial injury prior to the expiration of his employment he or she is entitled to ongoing temporary disability benefits. As long as the employee has an intention to return to the labor market, the responsibility to pay temporary disability remains with the temporary employer. The temporary disability ceases only if the employee retires with no intention of returning to the labor market. (*Gonzales v. WCAB 1998, 63 CCC 1477*)

MOONLIGHTING: If a worker holds two or more jobs at or about the time of the injury, then the average weekly earnings must be taken as the aggregate of his or her weekly earnings from all of these jobs. However, the wage loss from a job that did not cause the injury cannot be taken at a wage rate higher than the rate at the job where the injury occurred. Example, if earning \$10 per hour and injured, the employer must still calculate all of the lost hours of time from other employment but at no more than \$10 per hour even if the other job paid 15 per hour. (LC§4453(c)(2))

PERMANENT DISABILITY

A permanent disability is the irreversible residual of a work-related injury that causes impairment in earning capacity, impairment in the normal use of a member or a handicap in the open labor market. (*Brodie v. Workers' Comp. Appeals Bd. (2007) 40 Cal.4th 1313, 1320.*) Payments for permanent disability are designed to compensate an injured employee both for physical loss and reduction in earning capacity. (*Ibid*) When

the primary treater has released the injured worker from care, a decision is made by the treater regarding any and all medical issues necessary to determine the employee's eligibility for compensation. Such issues include but are not limited to the scope and extent of an employee's continuing medical treatment, the decision whether to release the employee from care, the point in time at which the employee has reached permanent and stationary status, and the necessity for future medical treatment. 8 CCR §9875(a)(4) In determining the percentages of permanent disability, account shall be taken of the nature of the physical injury or disfigurement, the occupation of the injured employee, and his or her age at the time of the injury, consideration being given to an employee's diminished future earnings capacity. LC§4660(a)

Pursuant to LC§4660(b)(1), the "nature of the physical injury or disfigurement" shall incorporate the descriptions and measurements of physical impairments and corresponding percentages of impairments published in the AMA Guides to the Evaluation of Permanent Impairment (5th Edition).

An employee's diminished future earnings capacity shall be a numeric formula based on empirical data and findings that aggregate the average percentage of long-term loss of income resulting from each type of injury for similarly situated employees. The AD shall formulate the adjusted rating schedule based on empirical data and findings from the Evaluation of California's Permanent Disability Rating Schedule, Interim Report (December 2003), prepared by the RAND Institute for Civil Justice, and upon data from additional empirical studies. LC§4660(b)(2).

Currently the trend in Worker's Compensation is the multiple cases that are addressing Permanent Disability and whether or not an injured worker can rebut the 2005 PDRS. If it is possible to rebut the 2005 PDRS, then what evidence can be presented to do this? In addition, injured workers struggle to find ways around the AMA Guides. The most recent decisions address these issues and concerns.

Here are just some of the most recent cases addressing concerns with Permanent Disability. These cases addresses issues such as ratings, offers of regular, modified, or alternative work, diminished future earnings capacity, the use of vocational experts in the area of diminished future earnings capacity, and the application of the 2005 PDRS.

One of the most significant cases with regards to Permanent Disability is the *Ogilvie* matter. There were multiple findings in this matter, with *Ogilvie I* and *Ogilvie II*. The following is only a brief overview of this case.

Ogilvie v. WCAB (7-29-11) 1st Dist. Div. 3

The conclusion to date on the *Ogilvie* matter is that "the application of the rating schedule is not rebutted by evidence that an employee's loss of future earnings is greater than the earning capacity adjustment that would apply to his or her scheduled rating due to nonindustrial factors. Rather, to rebut the application of the rating schedule on the basis that the scheduled earning capacity adjustment is incorrect, the employee must

demonstrate an error in the earning capacity formula, the data or the result derived from the data in formulating the earning capacity adjustment. Alternatively, an employee may rebut a scheduled rating by showing that the rating was incorrectly applied or the disability reflected in the rating schedule is inadequate in light of the effect of the employee's industrial injury." *Ogilvie v. WCAB A126344 and A126427*. The Court could not conclude on the record whether *Ogilvie* could make any such showing.

It should be noted that the court in their determination made some significant findings in their discussions. Some examples are that an employee may rebut a 2005 schedule by demonstrating that the earning capacity adjustment is incorrect or that the data demonstrating earning capacity was erroneous. Also, an employee may rebut a 2005 schedule by showing through expert vocational testing that the rating was incorrectly applied or that the disability reflected in the rating schedule is inadequate in light of the effect of the employee's industrial injury. This case also determined that there is no meaningful difference between compensation for "diminished future earning capacity" LC§4060(a)&(b)(2)) and "ability to compete in an open labor market." And finally, it is significant to understand that SB899 and LC§4660 did not change the prior case law that authorized the use of vocational experts to rebut the 2005 PDRS.

The decision of the WCAB was reversed and the matter was remanded to the WCAB for further proceedings consistent with this opinion and the award of permanent disability benefits to the Applicant was annulled.

***Cynthia Siegert, Applicant v. Cottage Health Systems, PSI, Administered by Keenan & Associates, Defendants* 2011 Cal. Wrk. Comp. P.D. LEXIS 300 (Panel Decision)**

The WCAB affirmed the decision of the WCJ wherein it was determined that Applicant incurred a 45 percent disability as a result of her 6/29/2006 injury to her lumbar spine. Applicant did not meet the burden of rebutting the scheduled DFEC factor *Ogilvie v. City and County of San Francisco* (2009) 74 Cal. Comp. Cases 248 (Appeals Board en banc opinion (*Ogilvie I*)) and *Ogilvie v. City and County of San Francisco* (2009) 74 Cal. Comp. Cases 1127 (Appeals Board en banc opinion (*Ogilvie II*)) because the opinion of Applicant's vocational expert did not constitute substantial evidence. This was based on the fact that the expert's opinions were based on the Applicant's inconsistent testimony regarding her loss of earnings and her testimony that she searched for jobs but could find none within her restrictions. This, by itself, was insufficient to rebut the DFEC portion of the 2005 PDRS.

COMPARE THE RESULTS OF THE ABOVE CASE WITH THE FINDINGS BELOW. THESE CASES ALSO ADDRESS THE *ALMAREZ/GUZMAN* DECISIONS.

Cynthia Siegert, Applicant v. Cottage Health Systems, PSI, Administered by Keenan & Associates, Defendants, 2011 Cal. Wrk. Comp. P.D. LEXIS 300 (Panel Decision)

The WCAB affirmed the WCJ's finding that the Applicant incurred a 45 percent PD as a result of her industrial 6/29/2006 date of injury to her lumbar spine when the AME's opinion was sufficient to rebut the scheduled impairment rating pursuant to *Alvarez v. Environmental Recovery Services/Guzman v. Milpitas Unified School District* (2009) 74 Cal. Comp. Cases 1084 (Appeals Board en banc opinion) (*Alvarez II*) and *Milpitas Unified School Dist. v. WCAB (Guzman)* 187 Cal. App. 4th 808, 115 Cal. Rptr. 3d 112, 75 Cal. Comp. Cases 837. The AME set forth facts and reasoning to justify his opinion that Applicant was in DRE Category V of *AMA Guides*, at top of 25 to 28 percent whole person impairment (WPI), because she had instability in her lumbar spine and numbness in her thigh. The AME's assessment of a 28 percent WPI was supported by his clinical and sensory exams as well as his clinical judgment, and the AME's WPI assessment was within the four corners of the *AMA Guides*.

Ofelia Rivera, Applicant v. Costco Wholesale Corporation, PSI, adjusted by Sedgwick CMS, Defendants 2011 Cal. Wrk. Comp. P.D. LEXIS 296 (Panel Decision)

In a split opinion, the WCAB affirmed the WCJ's finding that Applicant, who incurred an industrial injury to her wrists during a cumulative period ending on 5/24/2007, met her burden of proof to rebut the *AMA Guides* and established that she suffered a 19 percent PD impairment after the application of the Combined Values Table (CVT). The WCAB found that the AME's opinion on impairment, on which the WCJ had relied, met the requirements of *Alvarez v. Environmental Recovery Services/Guzman v. Milpitas Unified School District* (2009) 74 Cal. Comp. Cases 1084 (Appeals Board en banc opinion) (*Alvarez II*) and *Milpitas Unified School Dist. v. WCAB (Guzman)* 187 Cal. App. 4th 808, 115 Cal. Rptr. 3d 112, 75 Cal. Comp. Cases 837 because even though the AME did not explicitly state that the Applicant's PD was "most accurately" described with the addition of 3 percent WPI derived from her diminished ability to perform repetitive forceful activities, the WCAB found that this was clear from his report. In addition, the WCAB stressed that the AME exercised his professional judgment in concluding that the Applicant's PD was most accurately described as set forth in his report, staying within the four corners of the *AMA Guides* and providing an explanation regarding the bases of his conclusions.

Robert Chavez, Applicant v. International Paper, Defendant, 2011 Cal. Wrk. Comp. P.D. LEXIS 264 (Panel Decision)

The WCAB affirmed the WCJ's finding of a 1 percent permanent disability as a result of a 6/4/2008 right shoulder injury based upon the findings of the Panel QME's

report. The Applicant did not meet his burden of proof to rebut the AMA *Guides* under *Alvarez v. Environmental Recovery Services/Guzman v. Milpitas Unified School District* (2009) 74 Cal. Comp. Cases 1084 (Appeals Board en banc opinion) (*Alvarez II*) and *Milpitas Unified School Dist. v. WCAB (Guzman)* 187 Cal. App. 4th 808, 115 Cal. Rptr. 3d 112, 75 Cal. Comp. Cases 837 when the WCAB found that, although Applicant's treating physician diagnosed a massive and irreparable rotator cuff tear and opined that it would be most accurate to rate the injury as a shoulder arthroplasty yielding a 13 WPI, the Applicant did not establish that the injury impacted his activities of daily living or his ability to work sufficiently to warrant rating the injury as a shoulder arthroplasty. In addition, the treating physician did not explain his reasoning behind his conclusion that the rotator cuff tear was more accurately evaluated as a shoulder arthroplasty or compare the Applicant's measurable impairment resulting from similar conditions with similar impairment of function in performing activities of daily living. In addition, the Panel QME explained why a shoulder arthroplasty was NOT a proper analogy given the Applicant's range of motion and functional ability.

THE FOLLOWING RECENT DECISIONS APPLY TO OTHER ASPECTS OF PERMANENT DISABILITY

Rebecca Hanson, Applicant v. University of California Santa Cruz, PSI, Defendant, 2011 Cal. Wrk. Comp. P.D. LEXIS 276 (Panel Decision)

In a split opinion, the WCAB rescinded the WCJ's finding that the 1997 Schedule for Rating Permanent Disabilities applied to rate the permanent disability incurred by the Applicant as a result of her 9/18/2003 back and psyche injuries when the WCAB disagreed with the WCJ's determination that defendant's erroneous issuance of LC§4061 notice on 10/8/2003 was suffice to mandate application of 1997 Schedule, and held that exception in LC§4660(d) to application of 2005 Permanent Disability Rating Schedule is triggered when the last payment of TTD is made, not when notice is given. The Defendant did not actually stop paying TTD benefits until 2010 and Defendant's obligation to give notice under Labor Code §4061 arose upon its last payment of TTD in 2010. Since Defendant was not obligated to give notice prior to 1/1/2005, exception to the use of the 2005 PDRS was never triggered.

Maria Mercedes Felix, Applicant v. Sea Dwelling Creatures, Inc., State Compensation Insurance Fund, Defendants, 2011 Cal. Wrk. Comp. P.D. LEXIS 271 (Panel Decision)

The WCAB affirmed the WCJ's finding that the Applicant's low back injury of 1/4/2006 caused no PD based upon the report of the Panel QME. The Panel QME found

that Applicant's disability fell within DRE Lumbar Category I, which equated to a 0 percent WPI under AMA *Guides*, and that Applicant required no further medical treatment. The Panel QME's report was the only medical report in evidence, and, although the Panel QME proposed a 3% WPI for pain under Table 18-3 of the AMA *Guides*, the WCAB, applying principles in *Blackledge v. Bank of America* (2010) 75 Cal. Comp. Cases 613 (Appeals Board en banc opinion), found that since there was no other impairment to be "increased", there was no legal basis to allow a 3 percent WPI add on for pain.

Felix Lopez Heredia, Applicant v. Nunez Brothers Ranch, Zenith Insurance Company, State Compensation Insurance Fund, Defendants 2011 Cal. Wrk. Comp. P.D. Lexis 285

Labor Code §4660(d) states in relevant part "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 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."

Here, in the case of Mr. Heredia, the WCAB rescinded the WCJ's determination. The WCJ had held that the treating physician's pre-2005 report was sufficient to indicate existence of PD so as to trigger the exception to the application of the 2005 Schedule under Labor Code §4660(d). It was determined that the treating physician's report did not state that Applicant required VR and did not discuss whether Applicant would have PD associated with his injury. The WCAB concluded that the physician's finding of an abnormal MRI, need for conservative medical treatment, and potential need for surgery did not equate to an indication of PD.

Francis Lara, Applicant v. Bimbo Bakeries USA, ACE American Insurance Company, Defendants 2011 Cal. Wrk. Comp. P.D. LEXIS 281 (Panel Decision)

Labor Code §4658 describes increases and decreases in the amount of Permanent Disability Indemnity payments based on offers of regular, modified or alternative work from employers with 50 or more employees.

Here, in the case of Ms. Lara, the WCAB affirmed the WCJ's findings that the Defendant was not entitled to a 15 percent reduction in PD awarded to Applicant because the Defendant failed to establish that they offered Applicant regular, modified, or

alternative work in the form and manner prescribed by the AD as required by LC§4658(d)(3)(A) in order to receive such reduction. The form submitted was only partially filled out and the basis upon which the offer was made was not offered into evidence. This made the evidence unclear as to what the Applicant's restrictions were at the time the offer was made.

Cynthia Siegert, Applicant v. Cottage Health Systems, PSI, Administered by Keenan & Associates, Defendants, 2011 Cal. Wrk. Comp. P.D. LEXIS 300 (Panel Decision)

The final issue significant in the above case was that the WCAB affirmed the WCJ, holding that the Applicant who was awarded a 45 percent permanent disability as a result of her 6/29/2009 injury to her lumbar spine, was not entitled to a 15% increase in her PD award pursuant to LC§4658(d)(2) nor was the Defense entitled to a 15% decrease in the award when, although Defendant did not offer the Applicant regular, modified, or alternative work, it was unclear whether Applicant was able to return to any type of work with Defendant based on Applicant's testimony that she had relocated due to her husband's job transfer. In addition, the evidence showed that Applicant never responded to the Defendant's notice of intent to terminate her employment unless notified by the Applicant of her intent to return to work.

APPORTIONMENT OF PERMANENT DISABILITY

There are three basic fact patterns where apportionment is an issue. There is a prior industrial injury or illness, there is a prior non-industrial injury or illness or there is a subsequent non-industrial injury or illness.

LC§4663(a)&(b) states that apportionment of permanent disability shall be based on causation. Any physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability.

LC§4664(a) states that the employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of an occurring in the course of employment.

The following are the most significant and recent determinations on the issue of Apportionment. The first discussion is on the *Benson* determination which was one

of the first cases after SB899 and the reform of LC§§4663 and 4664. The second most significant case is the *Escobedo* case.

***Benson v. W.C.A.B.* (2009) 170 Cal. App. 4th 1535, 89 Cal. Rptr. 3d, 166, 74 Cal. Comp. Cases 113.**

In the case *Benson v. Workers' Comp Appeals Board* 170 Cal. App. 4th 1535 (2009), the court held that if an employee suffers from a specific injury and a cumulative injury, regardless of when the injury occurred, they are entitled to two separate awards — one for each injury. The worker is not entitled to a combined award. If the awards were combined, the percent of disability is higher. This could result in a longer payout period in direct contradiction to the legislative intent, the court ruled.

According to the AME, Applicant suffered two injuries; a specific on 6/3/2003 while reaching overhead and a cumulative trauma injury through 6/3/2003. On September 26, 2003, her disability was deemed permanent and stationary. The AME apportioned half of Benson's permanent disability to cumulative trauma and the other half to the specific injury.

In a unanimous decision, the Worker's Comp Appeals Board overturned the WCJ's holding and found that, because the AME found that there were two different injuries and both were equally responsible for the disability, Benson is entitled to receive 31 percent award for each injury in the amount of \$24,605 per injury. Each award is payable at \$185 per week for 133 weeks. The WLJ's award combined the two injuries into a 62 percent award, combining the two injuries for a total of \$67,016.25, payable at \$185 per week for 362.25 weeks. The difference between the amount of time found by the ALJ and the Board is caused by the non-linear benefit schedule, which more generously compensates more severe disabilities. As such, because a 62 percent award indicates a more severe injury, the award should last longer to greater compensate the injured employee.

The Court of Appeal agreed with the Board because the SB 899 reforms changed the apportionment discussion to focus on the cause or pathology of an injury and not the actual disability. The SB 899 amendments refer to a singular injury relating to the employer's liability stating employers are liable only for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment. As such, even though 62 percent of Benson's permanent disability was directly caused by more than one injury arising out of and occurring in the course of Benson's employment with Permanente, each distinct industrial injury directly caused only half of the permanent disability.

***Escobedo v. Marshalls and CNA Insurance Co.*, (2005) 70 CCC 604, Appeals Board en banc; 70 CCC 1506, writ denied**

In this case, the Court was clear that the language in LC §4663 did not limit “other factors” and therefore other factors that may be taken into consideration when determining apportionment are pathology, asymptomatic prior conditions and retroactive work preclusions, *provided that there is substantial medical evidence for these other factors*. It appeared in this particular case that the Court allowed for the apportionment to pathology based on the use of the doctor’s language of “it is medically probable that she would have fifty percent of the current level of knee disability at the time of today’s evaluation even in the absence of her employment at Marshalls.” This allowed the Court to determine the report to be substantial medical evidence. This case made the law that every apportionment discussion needs to reach the level of “did this apportionment discussion in this report rise to substantial medical evidence?”

This case also helped define what is substantial medical evidence? The Court states that it is reasonable medical probability, not speculative, based on pertinent facts, based on adequate examination and history, and reasoning in support of the conclusion. A doctor needs more than just state that the apportionment is based on reasonable medical probability.

PRACTICE TIP: MOST, IF NOT ALL, PERMANENT AND STATIONARY REPORTS ISSUED BY DOCTORS NOW STATE THAT THEY HAVE ADDRESSED APPORTIONMENT IN ACCORDANCE WITH THE LABOR CODE AND THE *ESCOBEDO* CASE. IF THE REPORT DOES NOT HAVE THIS TYPE OF LANGUAGE, YOU MAY NEED TO GO BACK TO THE DOCTOR TO ADDRESS APPORTIONMENT CORRECTLY OR RISK HAVING THE REPORT NOT REACH THE LEVEL OF SUBSTANTIAL MEDICAL EVIDENCE.

Karl Leet, Applicant v. Department of Corrections, State Compensation Insurance Fund, Defendants, 2011 Cal.Wrk.Comp. P.D. LEXIS 284 (Panel Decision)

In this case, the AME determined that Applicant’s disability in part resulted from psychiatric factors which could not be apportioned or allocated between his multiple injuries. Therefore, the WCAB affirmed the determination of the WCJ who found that Applicant incurred permanent total disability as a result of multiple back injuries on multiple dates and a cumulative trauma period of 1998 to 6/19/2000 with a 19 percent apportionment to a prior award under Labor Code §4664. However, the WCJ found that there was no justification for Labor Code §4663 apportionment between the injuries pursuant to the exceptions delineated under the *Benson* case.

Neil Lamont, Applicant v. Boeing, AIG/Chartis, California Insurance Guarantee Association for Fremont Insurance Company, in liquidation, Defendants 2011 Cal. Wrk. Comp. P.D. LEXIS 279 (Panel Decision)

In this case, the WCAB affirmed the arbitrator's finding that the solvent carrier was not entitled to reimbursement from CIGA in contribution proceeding for benefits paid to Applicant who incurred 100 percent PD from the combined effect of injuries on multiple dates including a cumulative trauma from 1979 through 9/21/1995 when solvent carrier was jointly and severally liable for PD award which was found to be unapportionable pursuant to *Benson* based upon AME's opinion that disability from injuries was "inextricably intertwined" and could not be parceled as between injuries, and insurance provided by solvent carrier constituted "other insurance" under Insurance Code §1063.1(c)(9), thereby relieving CIGA of liability.

***Michael Garvey, Applicant v. City of Los Angeles, PSI, c/o Tristar Risk Management, Defendants* 2011 Cal. Wrk. Comp. P.D. LEXIS 213 (Panel Decision)**

The WCAB found that Labor Code §4664 does not apply when injuries are rated using different standards. Here, Applicant suffered a heart/hypertension injury during a period of 6/8/1996 through 2/7/2002. There had been a prior award of permanent disability for coronary artery disease/hypertension injury which had been previously rated under a different schedule. The WCAB held that the Defendant failed to meet their burden of proving overlap so as to justify Labor Code §4664 apportionment of the prior award to the same body parts when the AME's retroactive rating did not justify apportionment because the AME was unable to accurately rate prior disability under *AMA Guides*.

***Aurora Realivasquez, Applicant v. Turbot Jet Products, Inc., State Compensation Insurance Fund, Defendants*, 2011 Cal. Wrk. Comp. P.D. LEXIS 241 (Panel Decision)**

The WCJ's determination was affirmed by the WCAB when the Defendants carried their burden under LC §4664 proving that 20.3 percent permanent disability awarded to the Applicant in 1998 for her injuries overlapped with permanent disability caused by Applicant's injuries during the cumulative period of 1/79 through 3/2000. Justification to such apportionment of the prior award occurred when there was overlap of subjective factors of disability based on repetitive pushing, pulling and work above shoulder level, which affected Applicant's same abilities to compete in the open labor market.

***George Parga, Applicant v. City of Fresno, American All Risk Loss Fresno, Defendants*, 2011 Cal. Wrk. Comp. P.D. LEXIS 238 (Panel Decision)**

In this case, the WCAB reversed the findings of the WCJ when it found the report of the panel QME's opinion did not constitute substantial evidence under Labor Code §4663. Due to this finding, the Defendants could not apportion half of Applicant's permanent disability following right toe injury to his non-industrial diabetes, because Applicant's diabetes was not causing impairment or disability at the time of doctor's evaluation.

SUPPLEMENTAL JOB DISPLACEMENT VOUCHERS

Before the discussion of a Supplemental Job Displacement Voucher, it should be determined whether or not the Applicant can be retrained and whether or not the Applicant can prove 100 percent Permanent Disability. The determination of 100 percent permanent disability made need the assistance of a vocational expert and an analysis of the *Montana* factors. The Montana Case, is the seminal case on loss of earning capacity, (California Supreme Court dating back to 1948). The Montana Case states:

“An estimate of earning capacity is a prediction of what an employee's earnings would have been had he not been injured . . . [A] prediction [of earning capacity for purposes of permanent disability] is“ complex because the compensation is for loss of earning power over a long span of time. . . . In making a permanent award, [reliance on an injured employee's] earning History alone may be misleading . . . [A]ll facts relevant and helpful to Making the estimate must be considered. The applicant's *ability to work, his age and health, his willingness and opportunities to work, his skill and Education, the general condition of the labor market, and employment opportunities for persons similarly situated* are all relevant.” 27 CCC 13

It is significant to understand that this case stresses that you take the Applicant individually and each individual Applicant's ability to work, that Applicant's age, etc., not the “average” Applicant in the labor market. The Applicant is taken as he or she is found. It cannot be assumed that he or she has skills or education for every job in the open labor market. The vocational expert can help what his/her skills are, his/her educational level, his/her age, his/her transferrable skills, and his/her handicaps from the work injury. This is to ensure that the analysis is thus individualized based on the attributes of each Applicant.

If after the *Montana* factors are considered, and the Applicant is not found 100 percent permanently disabled, and then the Applicant may be entitled to the Supplemental Job Displacement Voucher.

For injuries occurring on or after January 1, 2004

In accordance with 8 CCR §§10133.51 and 10133.52, the Applicant may be entitled to a Supplemental Job Displacement Voucher. The vouchers which are non transferable are payable directly to the vocational or educational institution. During the employee's attendance in the program, there is no provision for vocational rehabilitation maintenance allowance. The amount of the vouchers is dependent upon the employee's disability rating:

1-14%	\$ 4,000
15-25%	\$ 6,000
26-49%	\$ 8,000
50-99%	\$10,000

Within 10 days of the last payment of temporary disability, if not previously provided, the adjustor shall send the employee, by certified mail, the mandatory form "Notice of Potential Right to Supplemental Job Displacement Benefit Form." In order to be entitled to this benefit, there must be at least 1% of disability and there must be an inability to return to full duty within 60 days. In addition, there is no modified or alternative work available. As before, the modified work must be within a reasonable distance of the employee's residence, must be promised for a 12 month period and provide for a wage equal to the preinjury work if it is modified or at 85% if it is alternative work. Finally, in order to be eligible for the voucher, the Applicant must not have settled this benefit as part of a Compromise and Release.