

Workers' Compensation Case Law Update

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INDEX

AOE/COE

<u>Bakersfield City School Dist. v. WCAB</u> (Boyd) (2007) 35 CWCR 266, 72 CCC 1191	p.5
<u>Chavez v. WCAB</u> (2007) 35 CWCR 89 (certified for non-publication)	p.5
<u>City of Los Angeles v. WCAB</u> (DeLeon) (2007) 2d Dist., Div. 3, 10/25/07, nonpub.	p.6
<u>City of Turlock v. WCAB</u> (STK09 YZZZ) (2007) 35 CWCR 208, 72 CCC 931	p.7
<u>Dover v. St. Paul Travelers Insurance</u> (8/24/06) 35 CWCR 157	p.7
<u>DuFour v. WCAB</u> (2007) (certified for non-publication) 35 CWCR 238, 72 CCC 1081	p.8
<u>Lamers v. WCAB</u> (2007) 35 CWCR 152, 72 CCC 599 (5th District nonpublished)	p.8
<u>Rash v. WCAB</u> (2007) (certified for non-publication) 35 CWCR 178, 72 CCC 614.	p.9
<u>Ruvalcaba v. SCIF</u> (2007) 35 CWCR 92 (Board panel decision)	p.10

APPORTIONMENT

<u>Beck v. CNA Cas. of Calif.</u> (6/25/07, OAK 298520, 326209) Board panel decision	p.11
<u>Brodie v. WCAB, Welcher v. WCAB, Strong v. WCAB, Williams v. WCAB</u> (Supreme Court) (5/3/07) 40 14 th 1313, 35 CWCR 143, 72 CCC 565	p.12
<u>Ehret v. State of California, California Highway Patrol</u> (2007) 35 CWCR 96 (Board panel decision)	p.13

ATTORNEY'S FEES

<u>Sambat v. United Airlines</u> (2006) 35 CWCR 158 (panel decision)	p.14
<u>Vierra v. WCAB</u> (2007) 35 CWCR 231, 72 CCC 1128	p.14

CIGA

<u>California Insurance Association v. WCAB</u> (Gutierrez) (2006) (non published opinion) 35 CWCR 47, 71 CCC 1661.	P.16
--	------

EMPLOYMENT

<u>Heiman v. WCAB</u> (2007) 149 Cal. App. 4 th 724, 35 CWCR 81, 911, 72 CCC 314	p.17
---	------

MEDICAL LEGAL

<u>Laing v. WCAB</u> (2007) (certified for non-publication) 35 CWCR 175, 72 CCC 767.	p.18
<u>Rodas v. Travelers Casualty and Surety</u> (4/20/07) 35 CWCR 156 (Board panel decision)	p.18
<u>Romero v. Costco Wholesale</u> (2007) 35 CWCR 186, 72 CCC 824 (significant panel decision).	p.19
<u>Wixom v. City of Concord</u> (2007) 35 CWCR 217	p.19

MEDICAL TREATMENT

<u>Davenport v. Travelers Property and Casualty Company</u> (2007) 35 CWCR 58 (WCAB panel decision)	p.21
<u>Henkel v. State Compensation Ins. Fund</u> (2007) 35 CWCR 188.	p.21

<u>Hodgman v. WCAB</u> (2007) 155 CA4th 44, 35 CWCR 259, 72 CCC 1202	p.22
<u>Schryer v. Southern Calif. Edison</u> (8/29/07 , SBR 187767) Board panel decision	p.23
<u>Stokes v. California Department of Mental Health</u> (2007) 35 CWCR 213, 72 CCC 996 (significant panel decision)	p.24
<u>Sutton v. WCAB</u> (2007) 35 CWCR 264, 72 CCC 1227	p.26

PENALTIES

<u>Jackson v. State Compensation Insurance Fund</u> (2007) 35 CWCR 215	p.27
<u>Kastning v. Allied Distributing Co.</u> (2007) 35 CWCR 245.	p.27
<u>Vega v. Barrett Business Services</u> (2007) 35 CWCR 244.	p.28

PERMANENT DISABILITY

<u>Audiss v. City of Rohnert Park</u> (2007) 35 CWCR 123	p.29
<u>Baglione v. AIG</u> (2007) (en banc) 35 CWCR 21	p.29
<u>Baglione v. AIG</u> (2007) 35 CWCR 121, 72 CCC 444 (en banc) (Baylione II).	p.30
<u>Chang v. WCAB</u> (2007) 153 CA4th 750, 35 CWCR 209, 72 CCC 921	p.31
<u>City of San Diego v. WCAB</u> (Brooks) (certified for non-publication) 35 CWCR 235, 72 CCC 1071	p.31
<u>Costco Wholesale Corp. V. WCAB</u> (Chavez) (2007) 151 CA4th 148, 35 CWCR 147, 72 CCC582.	p.31
<u>Davenport v. Travelers Property and Casualty Company</u> (2007) 35 CWCR 58 (WCAB panel decision)	p.32
<u>Energetic Painting & Drywall v. WCAB</u> (Ramirez) (2007) 153 CA4th 633, 35 CWCR 209, 72 CCC 937	p.33
<u>Gilliland v. Safeway</u> (2007) 35 CWCR 271, 72 CCC ____	p.33
<u>Hernandez v. USF&G</u> (5/4/07) 35 CWCR 155(Board panel decision)	p.34
<u>HSR, Inc. v. WCAB</u> (Mariscal) (2007) 35 CWCR 262, 72 CCC	p.34
<u>Joiner v. WCAB</u> (2007) 35 CWCR 210, 72 CCC 943 (nonpublished)	p.35
<u>Lyngso Garden Materials Inc. v. WCAB</u> (Ruiz) (2007)	p.35
<u>Magana v. Wausau Business Ins. Corp.</u> (2007) 35 CWCR 242	p.35
<u>Minatta Transportation v. WCAB</u> (Lanning) (2007) 35 CWCR 209, 72 CCC 950(nonpublished)	p.36
<u>Pendergrass v. SCIF</u> (2007) (<i>en banc</i>) 35 CWCR 26, 72 CCC 95	p.36
<u>Pendergrass v. State Compensation Insurance Fund</u> (2007) (en banc) 35 CWCR 124, 72 CCC 456 (Pendergrass II)	p.37
<u>SCIF v. WCAB</u> (Echeverria) (2007) 146 CA4th 1311, 35 CWCR 1, 72 CCC 33	p.38
<u>SF Marriott v. WCAB</u> (Yamat) (2007) 35 CWCR 210, 72 CCC 1103(nonpublished)	p.38
<u>Trader Joe’s Company v. WCAB</u> (Evets) (2007) 35 CWCR 51, 72 CCC 204.	p.39
<u>University of California San Francisco v. WCAB</u> (Rand) (2007) 35 CWCR 210, 72 CCC 1108 (nonpublished)	p.39
<u>Vera v. WCAB</u> (2007) 35 CWCR 233, 72 CCC 1115	p.40
<u>Washington Mutual v. WCAB</u> (Helm) (2007) 35 CWCR 210, 72 CCC 962(nonpublished)	p.40
<u>Zenith Ins. Co. v. WCAB</u> (Azizi) (2007) 153 Cal. App 4 th 461, 35 CWCR 177, 72 CCC 785.	p.41

PRESUMPTION

<u>Leprino Foods v. WCAB</u> (Owens) (2007) 35 CWCR 151 72 CCC 605 (5th District, nonpublished)	p.42
<u>Muna v. WCAB</u> (2007) 35 CWCR 263, 72 CCC 1219	p.42

PROCEDURE

<u>Agredano v. WCAB</u> (2007) (non-published Court of Appeal opinion) 35 CWCR 112, 72 CCC 381.	p.44
<u>Linam v. WCAB</u> (2007) 35 CWCR 86, 72 CCC 332 (certified for non-publication)	p.44
<u>Mohamed v. Exxon-Mobil Corp.</u> (2007) 35 CWCR 59	p.45
<u>Nestle Ice Cream Company v. WCAB</u> (Ryerson) (2007) 146 CA4th 1104, 35 CWCR 3, 72 CCC 13	p.46
<u>Philips v. WCAB</u> (2007) (certified for non-publication) 35 CWCR 117, 72 CCC 406.	p.47
<u>Ramallah, Inc. v. WCAB</u> (McKinley) (2007) 35 CWCR 181, 72 CCC 772 (certified for non-publication).	p.48
<u>Sarabi v. WCAB</u> (2007) 151 CA 4 th 920, 35 CWCR 150, 72 CCC 778	p.49
<u>Scott Pontiac GMC v. WCAB</u> (Olsen) (2007) 35 CWCR 84, 72 CCC 346 (certified for non-publication)	p.50
<u>Shannon v. CIGA</u> (2007) 35 CWCR 260	p.50
<u>Wal-Mart Stores Inc. v. WCAB</u> (Collier) (2007) 35 CWCR 52, 72 CCC 210 (Certified for non-publication)	p.51

PSYCHE

<u>Puga v. WCAB</u> (2007) 35 CWCR 54, 72 CCC 195 (non-published)	p.53
---	------

SERIOUS & WILLFUL

<u>Elk Grove Unified School District v. WCAB</u> (Stroth) (2007) (certified for non-publication) 35 CWCR 114, 72 CCC 399	p.54
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TEMPORARY DISABILITY

<u>County of San Joaquin v. WCAB</u> (Davis) (2007) 147 Cal. App. 4 th 1459, 35 CWCR 45, 72 CCC 187	p.55
<u>Cruz v. Auto Dealers Comp. of Calif.</u> (2007) 35 CWCR 268, 72 CCC 1281(en banc)	p.55
<u>Gunzenhauser v. WCAB</u> (2007) (certified for non-publication) 35 CWCR 235, 72 CCC 1087 . . .	p.56
<u>Hawkins v. State Compensation Ins. Fund</u> (Amberwood Products) (2007) (en banc decision) 35 CWCR 183, 72 CCC 807.	p.56
<u>Norwood v. City of Los Angeles</u> (2007) 35 CWCR 272, 72 CCC ____	p.57
<u>Van Ness v. Fireman's Fund Ins. Co.</u> (7/25/07, MON 324743) Board panel decision	p.57

132(a)

<u>Anderson v. WCAB</u> (2007) 149 Cal. App. 4 th 1369, 35 CWCR 109, 72 CCC 389	p.59
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AOE/COE

Bakersfield City School Dist. v. WCAB (Boyd) (2007) 35 CWCR 266, 72 CCC 1191

Applicant worked at the school district fixing air conditioning units at various school sites. On 8/31/06 while traveling between such sites, and stopped at a traffic light within several blocks for four schools, he noticed a police officer chasing a suspect. He tried to assist a police officer and in attempting to detain the fleeing suspect he tripped and suffered a right shoulder injury.

The employer awarded this good neighbor behavior by denying the claim, indicating that his air conditioning job not include arresting a suspect chased by the police. His response was that he was concerned that the fleeing gentleman might enter one of the nearby schools, among other contentions.

The trial judge did not find applicant credible, thinking the account of his intentions an after-the-fact rationalization. The Board panel reversed, finding that the worker was reacting to an emergency situation and human behavior cannot be neatly pigeonholed and he was engaged in an activity which was reasonable within the time and geographic limits of his employment and thus was acting either expressly or impliedly within the course of his employment, though obviously not duly his normal work activities.

The Fifth District Court of Appeal agreed with the Board that an employee acting in response to an emergency situation or exercising common decency does so within the course of employment. It is a reasonable expectation under the employment contract that situations requiring such human responses will occur. The court rejected defendants' claim that applicant was not protecting the employer's property, did not have permission to deal with the suspect and was not injured on the employer's premises while aiding a coworker.

Because of his perception of danger to schools in the area and absent a specific employer policy prohibiting such conduct, the Board's decision met the substantial evidence test.

Chavez v. WCAB (2007) 35 CWCR 89 (certified for non-publication)

The applicant alleged an industrial injury occurring on October 11, 2002. The applicant alleged that he told the office manager about the injury when she called and told him not to pick up his checks because the company's Vice President would deliver them directly to the vineyards. The applicant admitted that he was not sure that the office manager understood what he was telling her.

Later that afternoon the Vice President told the applicant and the other foreman that they were laid off and delivered the final paychecks and drove them home. The applicant did not tell him about the injury during the trip home, but later in the day, after the layoff, the applicant visited the company doctor and filed a claim form a week later.

At Trial the Judge ruled the claim barred as a post termination filing under Labor Code Section 3600(a)(10). He found the applicant did not prove he gave notice of his injury before being notified of his layoff.

This was appealed and the WCAB denied reconsideration adopting the Judge's recommendation.

The applicant sought review in the Fifth District and in its memorandum opinion it upheld the WCAB.

The applicant did not submit a claim form until a week after the layoff and the applicant's efforts to convince the Judge that he gave verbal notice prior to the layoff were unsuccessful. His testimony and that of his other foreman were found to be inconsistent and incredible. They also emphasize that it wasn't plausible that during the ride home there would be no discussion of the injury with the Vice President. However, the office manager had testified that she and the applicant had always conversed in English and the applicant did not report an injury nor call her on the date in question.

The Court went on to indicate that prejudice under 5403 is not an element of a 3600(a)(10) defense.

City of Los Angeles v. WCAB (DeLeon) (2007) 2d Dist., Div. 3, 10/25/07, nonpub.

Applicant was an accountant for the city and traveled to Atlantic City, New Jersey for a conference of Philippine-American-Canadian CPAs. The attendance was not mandatory and he was required to be a licensed CPA for his job. He did get some continuing education credit at the conference to help maintain that license which qualified him for a small salary bonus by the city. He was accompanied by his wife, also a city accountant, who intended to visit friends and family in the area. Before the conference began, applicant fell and hit his head while walking back to the hotel after lunch. He subsequently died.

The trial judge found the death compensable in that applicant's attendance was a benefit to the employer. Further the salary bonus was contractual and the city encouraged accountants to attend training to keep their licenses current. The judge found that he was a commercial traveler and also on a special mission. Recon was denied 2-1 with the dissenting commissioner questioning whether the convention attendance was a benefit to the employer and noting that there was no requirement that he be a CPA for his job.

The Court of Appeal overturned the Board's decision. The court noted that the city did not require any accountant to have a CPA license. Traveling to the convention was not expressly or impliedly authorized. The city didn't reimburse for CPA course work and the city didn't benefit from the licensure and considered its own training adequate for its accountants. The bonus was a reward for going beyond the requirements of the employment.

After rejecting the commercial traveler aspect, the court then rejected the special mission analysis. To be compensable, a special mission must be extraordinary compared to ordinary duties, and must be within the

course of employment and undertaken at the express or implied request of the employer and benefit the employer.

Again, the court pointed out that city didn't require accountants to have CPA licenses as it was not necessary for the job. There was no incentive for hiring or promotion purposes in the worker having a CPA license. The city did provide training which could be credited toward a CPA license but did not offer sufficient classes for that licensure. It encouraged the licensure as a personal achievement but otherwise did not gain any benefit from it. Only 13% of the accountants working for the city had CPA licenses, which were clearly not a part of the contract of employment. The court panel denied death benefits to the widow.

City of Turlock v. WCAB (STK09 YZZZ) (2007) 35 CWCR 208, 72 CCC 931

Applicant worked for a 16 years as a maintenance worker in the city's sewage system. He was exposed to raw sewage on a daily basis. He wore gloves which would often fill with sewage and he would slip down the manhole ladders, skin his legs and come in contact with sewage. He contracted Hepatitis C. No nonindustrial factors were present such as use of intravenous drugs, homosexual acts or a blood transfusion. Applicant filed a claim and his Qualified Medical Examiner indicated it was well-known that hepatitis C is present in human feces and medically probable that applicant acquired the disease from his exposure to raw sewage. The Defense Qualified Medical Examiner was of the opinion that there was a lack of literature associating hepatitis C with water treatment workers.

The trial judge felt applicant's Qualified Medical Examiner more persuasive than the Defense Qualified Medical Examiner finding unsatisfactory the Defense Qualified Medical Examiner's view "that applicant simply developed the disease from unknown sources." The panel denied reconsideration.

The 5th District in the memorandum opinion did not find applicant's Qualified Medical Examiner report speculative or conjectural, he set forth details on exposure and applicant's work activity history. The Defense Qualified Medical Examiner actually listed in his report a study of sewer workers which connected hepatitis C with that activity. Further, that physician provided no alternative explanation as to the causes of applicant's contraction of hepatitis C.

The court felt that the petition was without merit and awarded an applicant's attorneys fee under sections 5801.

Dover v. St. Paul Travelers Insurance (8/24/06) 35 CWCR 157

Applicant was a machinery engineer who injured his back on 1/1/05, working on a conveyor belt. He could not report the injury because the supervisor had left for the day. On returning to work on 1/2/05, the supervisor took him to the front office and revealed that his employment was to be terminated. The worker

then told his supervisor about his injury. The worker, supervisor and manager discussed the termination and injury and applicant was referred to a medical clinic.

Nine days later applicant filed an Application. The case was heard the following September with further testimony in early February 2006. The judge found that applicant's claim was barred by section 3600(a)(10).

A Board panel indicated that if a claim for a physical injury is filed after the notice of termination, it is barred. The panel considered that the notice of injury was contemporaneous with the notice of termination and does not bar the claim. The purpose of the statute wasn't intended to deny claims to an injured worker simply because the employer intended to let him off. The intent of the statute was to bar claims made in retaliation for layoff.

DuFour v. WCAB (2007) (certified for non-publication)

In December of 2003 Police officer passed away at home after two days of flu like symptoms. His widow filed a death claim invoking the blood born infectious disease presumption of 3212.8.

The coroner's report concluded that decedent had died from undetermined natural disease. An outside county coroner agreed with the official findings. The employer's QME indicated that the death was probably from an infectious origin caused septicemia followed by septic shock and vascular collapse. The applicant's QME initially viewed the death as non-industrial, probably the result of a flu type viral infection. He changed his mind indicating that although no blood born pathogen appeared in the blood sample, he concluded that the death was caused by some type of blood borne disease, very broadly defined. Irrespective of whether a pathogen was found, the lethal organism still traveled through the blood thus the cause of death would meet the 3212.8 presumption.

The Judge decided that the presumption did not apply and the applicant sought reconsideration. This was accepted by the Board.

The applicant filed a Petition for Writ and, in a non-published opinion, the Court of Appeal affirmed indicating that the basic facts giving rise to the presumption had not been established. The applicant never established that a blood borne infectious disease developed or manifested itself during decedent's employment. That was the applicant's burden. The Court agreed with the WCAB that the 3212.8 presumption was to apply to diseases transmitted by blood, like AIDS and Hepatitis, rather than by any organism that can travel in the blood stream of its host.

Lamers v. WCAB (2007) 35 CWCR 152, 72 CCC 599 (5th District nonpublished)

The 5th District, denied review of WCAB decision barring a death claim as coming within the going and coming rule.

Applicant was a security guard, just recently hired by the employer, going to different job sites for training. He then was assigned to patrolling a bridge and while driving his own vehicle to the job site, had an accident which ultimately caused his death. The trial judge held the claim barred by the going and coming rule and a Board panel agreed unanimously.

On appeal, applicant argues that decedent had no established worksite and hours. He also argued that his case was an exception to the going and coming rule because he used his own vehicle.

The court felt that applicant did not confer any special benefit on the employer by using the vehicle. He did not go between worksite and worksite in a particular day. He knew where he had to go each day. There was also no evidence that the vehicle was needed for his job duties. The applicant's job duties were to be on foot. There was no evidence the employer either explicitly or implicitly required him to drive his personal car to work as a condition of employment.

The court rejected arguments that applicant needed to use his vehicle because public transportation was infeasible, the worksite was an hour from home and the shift he worked ended late at night. The court felt that taking such factors into consideration would lead to subjective line drawing.

Rash v. WCAB (2007) (certified for non-publication) 35 CWCR 178, 72 CCC 614

In a disputed AOE/COE case, the Court of Appeal found in favor of the applicant.

The applicant was a Deputy Sheriff and a member of a voluntary mounted unit in which the officers use their own horses for functions such as crowd control, public relations etc. They were paid a small salary differential and reimbursed for some but not all expenses. There were expected to have their horses ready at all times.

The applicant attended a horse shoeing class when called to fill in for a co-worker at an upcoming rodeo detail. He took his horse to school with him to shoe it in class and on his return he was injured in an automobile accident.

After Trial the Judge denied the claim, holding that the applicant had used farriers to shoe his horse before and the employer did not in anyway encourage the shoeing to be done at the class. He was not on a special mission and thus was not injured in the course of employment.

WCAB affirmed the decision, but the Court of Appeal reversed it. The Court agreed with the WCJ's reasoning that the injury arose out of employment because he was doing an activity that benefitted that employer. They disagreed with the Judge that the applicant was not in the course of the employment. The Court noted that in exchange for a small increase in salary the applicant maintained a privately owned horse in good health and shod at all times, available for duty any time of the day or night. The Court indicated that there was no evidence to suggest his activities were beyond that scope both contemplated by his

employment. The Court indicated that the applicant's decision to attend the course could have been considered a recreational activity but when he brought his horse to the class to be shod to be available for duty that this was a reasonable expectancy of his job and therefore compensable.

Ruvalcaba v. SCIF (2007) 35 CWCR 92 (Board panel decision)

The applicant filed a claim alleging that she sustain a cumulative injury arising out of her employment ending on October 23, 2002.

A lien claimant chiropractic office provided treatment in November and December 2002 and from November through January of 2003 totaling a little over \$2,000. The insurance carrier denied liability for the claim on February 3, 2003.

The lien claimant continued to provide treatment through April 2003 and filed a lien of a little over \$9,500.

Eventually the applicant's claim was settled by way of a Compromise and Release Agreement with a Thomas finding, in August 2004.

At the hearing in June 2005 the lien claimant reduced its lien to a little over \$2,000 owing for treatment provided before the claim was denied. This treatment was awarded by the Judge citing Labor Code Section 5402(c) which was amended on April 19, 2004. The Judge specifically found that it applied retroactively to the lien.

Defendant filed a Petition for Reconsideration indicating that 5402(c) should not be applied retroactively.

The Board panel affirmed the Judge's decision stating that the retroactivity of the substantive amendments in SB 899 had been fully discussed earlier in the case of *Kleemann*, and further found that despite defendants contention that SB 899 was to cut costs, there was another intent in enacting 54029(c), i.e. to assure prompt investigation and processing of claims.

APPORTIONMENT

Beck v. CNA Cas. of Calif. (6/25/07, OAK 298520, 326209) Board panel decision

Applicant injured her right leg while working as a housekeeper for a motel chain in mid-May 1998 while bending on her left leg and experienced pain in the right knee. X-rays showed degenerative changes in both knees and hips.

Applicant had right hip surgery in August 1999 and then left hip surgery in January 2004, both covered by the carrier.

Applicant was seen by a pain management evaluator who indicated in February 2006 that the injury itself was minor in nature and that applicant had fairly advanced degenerative changes. The disability resulted from a combination of the specific injury and non-industrial genetic, habit factors and life exposure.

The doctor opined as follows:

"I believe the majority if not all of her current disability is related to her degenerative hip and knee disease which has some small contribution from her limited work exposure and injury.

"Absent the work injury, it is not possible to identify that the applicant would have PD. Conversely, absent the pre-existing condition, the work activity would, from a medical probability standpoint, not have resulted in PD either. "Based on a 'but for test' I cannot state with medical probability how much PD would exist absent the injury or the pre-existing condition, but the major cause of the PD is clearly the pre-existing condition. "We thus have an older woman with a substrate of degenerative disease that was lit up or kindled by a relatively minor event at work. If the employer is to take the worker as she is found, then we would, as in prior days, apportion 100% to industrial causation. If we are to truly apportion to what caused the disability, then I would find for 90% non-industrial causation essentially to her underlying degenerative disease and 10% industrial, thus allowing for at least some contribution from the work event."

Thereafter, applicant's attorney filed a cumulative claim ending on the same date as the specific. The trial judge found 58% permanent disability without apportionment. The judge found the AME's analysis inconsistent, speculative and not substantial evidence per *Escobedo v. CNA Ins. Co.* (2005) 33 CWCR 100, 70 CCC 604.

Predictably, defendant petitioned for reconsideration. A Board panel felt that further proceedings to clarify the AMEs opinion will required since the cumulative claim was filed after the AME evaluation.

An evaluator can make an apportionment based on medical expertise stating the approximate percentage of PD caused by a degenerative condition. Even though percentages provided are couched as approximations, they require some intuition and medical judgment. But such conclusions are valid if the physician gives the factual bases for his determinations based on his expertise.

In this case, there was a high degree of pre-existing disease and only a minor injury. The report did not address the later-filed cumulative claim. The AME should be given the opportunity to discuss the cumulative injury and explained in a coherent manner what part of causation of applicant's PD was caused by the pre-existing conditions found. Thus the matter was returned to the trial judge to deal with the issues of PD and apportionment.

Brodie v. WCAB, Welcher v. WCAB, Strong v. WCAB, Williams v. WCAB (Supreme Court) (5/3/07)

In May, the Supreme Court decided the heavily litigated issues of apportionment of disability for prior or nonindustrial cases per the terms of SB599. The court decided that Fuentes v. WCAB(1976) 16 C3d 1, 4 CCC 42 is alive and well and still governs apportionment of permanent disability.

In Brodie, applicant had a 2000 specific and cumulative through 2002 resulting in 74% permanent disability. Earlier, he had injuries resulting in 44 ½% award. The Judge gave him 29 ½% and reconsideration was denied. In Welcher, applicant had a prior 1990 injury and 62 ½% permanent disability award and then a continuous trauma claim to the right leg requiring amputation causing 71% permanent disability. The judge gave 8% and reconsideration was again denied. In Strong, the applicant had a 1995 left injury with a 34 ½% award and injuries four years later to several body parts resulting in a 42% award and then a back injury in 2002. The parties stipulated that after the back injury he had 70% permanent disability. The trial judge awarded 10% permanent disability apportioning the remaining 60% to the prior injuries. In Lopez, applicant injured her back and legs. Her overall permanent disability was stipulated to 100% with 79% attributable to the work injury and 21% other causes. She was rated out at that 79% with a life pension. Reconsideration was denied. In Williams, applicant had a 28% rating for a back injury and the later back injury in 2003 stipulated at 43%. The judge awarded applicant 15%.

The Supreme Court went over the apportionment problem created by the legislative change in April 1972 when permanent disability started being paid in a geometric progression and not a linear fashion. The result was the now famous “Formula A” of Fuentes, subtracting percentages of disability to arrive at the permanent disability after apportionment. The Fuentes court based that on Labor Code Section 4750 which indicated that permanent disability from a subsequent injury was not to be rated in conjunction with any prior disability.

SB899 did away with section 4750 on the surface and amended section 4663. The court indicated its view that the Legislature intended to do away with the abuses in old section 4663 and 4750 (for example, a claim of physical rehabilitation from a prior injury liberally construed by the Board) with its new versions of sections 4663 and 4664. There is no indication that the Legislature meant to change Formula A for apportionment purposes and the history of the new legislation shows a clear intent to charge employers on that portion of permanent disability directly caused by the injury. Section 4658 tables are meant to compensate for a current injury and not applicant’s overall permanent disability.

Fuentes wins and Dykes and Nabors lose.

Ehret v. State of California, California Highway Patrol (2007) 35 CWCR 96 (Board panel decision)

The applicant was employed as a Peace Officer by the Highway Patrol from 1981 through 2004.

In 1996 he was awarded permanent disability of 16 ½% for a spinal and shoulder claim and 25% for a coronary disability.

After he stopped working in September 2004 he filed another claim alleging another heart injury.

The defendant requested a medical evaluation pursuant to Labor Code Section 4060. The applicant was sent a list of three qualified evaluators. The applicant failed to select one so the defendant did. The examination took place.

Subsequently the applicant obtained an attorney who had the applicant evaluated by a different med-legal evaluator, Dr. Blau.

This matter proceeded to Trial and Dr. Blau's report was received over defendant's objection. The applicant unsuccessfully objected to the first report.

The Judge requested a rating based on factors taken from both doctors reports and ultimately issued a Finding that applicant did sustain a cumulative heart injury and that the injury caused 44% permanent disability without apportionment.

The defendant sought reconsideration contending that Dr. Blau's report should not be admitted and that the WCAB should apportion out the prior permanent disability Award.

The defendant sought reconsideration which was granted.

The Board specifically indicated that Dr. Blau's report was not obtained in accordance with either Labor Code Section 4062.1 or 4062.2, therefore it was inadmissible.

On the apportionment issue they specifically held that the anti-attribution clause of Labor Code Section 3212.3, did not apply to 4664 apportionment although it might apply to 4663 apportionment. Since 4664 contains a conclusive presumption and since it doesn't accept 3212.3 (as does 4663), apportionment pursuant to 4664 must be found.

Accordingly the WCAB rescinded the Findings and Award and remanded the case to the Trial level for further proceedings.

ATTORNEY'S FEES

Sambat v. United Airlines (9/29/06) 35 CWCR 158 (panel decision)

Applicant injured his back working as a ramp serviceman for the airline in 2001. His counsel filed an Application 2 years later.

The case was tried in March 2006. The parties stipulated that applicant had been paid temporary disability from October 2002 through June 2003, permanent disability had been advanced from late February 2004 through early September 2005 for little over \$15,000, and the injury caused 19% permanent disability, and that there was need for further medical treatment. The only issue was credit for overpayment of temporary disability and permanent disability and attorney's fees. Less than four months later, the judge issued a decision finding that defendant is not entitled to a credit for temporary disability or permanent disability overpayment because "funds are not available." The judge also awarded a nominal fee of \$300 to applicant's attorney.

Applicant's counsel Petitioned for Reconsideration, arguing the judge had not made findings of fact on the extent of temporary disability, permanent disability, and need for care and that the fee was inappropriate.

The Board panel agreed with applicant's attorney. In this instance as defendant was aware that applicant was represented when it began advancing permanent disability. It is defendant's responsibility to withhold a percentage of permanent disability advances to pay the fee. Having failed to do so, defendant should not be allowed any credit against the fee. The case had to be remanded for the award of a reasonable fee to counsel based on the responsibility assumed, care exercised, time involved, etc.

Further, the panel indicated that the stipulations needed to be translated into findings of fact as a judge was under obligation to make findings of all facts involved in the controversy.

Vierra v. WCAB (2007)

In a confusing opinion regarding attorneys fees, the Court of Appeal found that a fee agreement entered into by the applicant and his attorney was not binding and that the WCAB has final say over the amount of the fee.

The applicant while in pro per obtained a Stipulated 78% permanent disability Award. The defendant then attempted to reduce Award and the applicant sought services of an attorney to represent him. A fee agreement was executed that called for the payment of the lesser of \$225 per hour or 12% of the final percent of permanent disability indemnity awarded after proceedings to reduce the Award were concluded.

The WCJ held that the agreement was not binding on applicant since a statutory scheme exists for attorney's fees. The attorney then sought reconsideration and/or removal. The WCAB dismissed the Petition for Reconsideration and denied the removal quoting from the WCJ that as a practical matter the counsel was not aggrieved since one or more funds were available from which to award a fee. The original Award is not only accruing and the attorney may seek to withhold some money or he may be entitled to a fee under Labor Code Section 5410.1 against the defendant directly for successfully resisting the Petition to reduce the Award. This was appealed and the Court of Appeal and for some reason the Court decided to accept same.

Citing Labor Code Section 4906 the Court of Appeal specifically found that the agreement is not binding and that the WCAB has final say over the enforcement of the agreement. Although the law does not forbid the fee contracts, to require approval of the fee agreement before the work is done would be contrary to the policy of 4906. "Once services are rendered, the WCJ may approve, increase, or reduce the fees provided for any agreement, taking into consideration the factors listed in section 4906..."

CIGA

California Insurance Association v. WCAB (Gutierrez) (2006) (non published opinion) 35 CWCR 47, 71 CCC 1661

The Court of Appeal overturned a prior WCAB Decision and held that since UC is an agency of the State of California, its lien is not a covered claim that CIGA must pay.

EMPLOYMENT

Heiman v. WCAB (2007) 149 Cal. App. 4th 724, 35 CWCER 81, 911, 72 CCC 314

The applicant sustained an admitted injury while working for a rain gutter service. An uninsured condominium home owners association had requested its property manager, Pegasus, to obtain bids and Pegasus selected the unlicensed uninsured contractor. Pegasus was also uninsured.

The applicant was paid \$65 per day and the job was expected to last two days. The applicant was injured when the gutter touched a power line.

Although the Judge awarded 90% permanent disability he found that the applicant failed to meet the threshold 52 hour and \$100 requirements of Labor Code Section 3352(h). He found that neither the home owners, their association nor the property manager were liable. The only liable party was the contractor. Both the applicant and the UEF sought reconsideration.

Reconsideration was granted and the permanent disability issue was deferred Citing the *Blew v. Horner* cases they indicated that the liability rested with Pegasus, the property manager.

Pegasus appealed and the Court of Appeal concluded that both the property manager and the contractor were dual employers. Moreover they found that the home owners association was also liable as it was a legal entity separate from the individual owners whose liability was precluded by Labor Code Section 3352(h).

Since the rain gutter contractor hired the applicant directly and the applicant provided service for him, he was clearly an employee of the contractor.

They found the property manager to be liable as they were an independent contractor and did all the negotiations. Pegasus hired the unlicensed, uninsured contractor and therefore, had liability.

They specifically found that Labor Code Section 3351(d) and 3352(h) did not apply to the Pegasus.

With respect to the home owners association they found that it was not an owner thus they could not benefit from Labor Code Section 3351(d) and 3352(h). They further went on to indicate that the duties of the injured worker and the unlicensed contractor were in the trade and business of the association thus excepting 3351(d). The individual home owners however could not have liability in that the hour level of the statutes were not met in the job at hand.

MEDICAL LEGAL

Laing v. WCAB (2007) (certified for non-publication) 35 CWCR 175, 72 CCC 767

The applicant sustained an admitted injury to his low back in 1987. By 2006 his treating physician recommend low back surgery to which the defendant objected. They initially obtained a QME report who agreed that surgery was necessary but recommended the different kind. The parties then selected another doctor as an AME for a second opinion but the applicant withdrew from the AME agreement. He attended the examination anyway and an opinion resulted indicating that the applicant was not a surgical candidate.

At hearing the Judge admitted all reports into evidence and indicated that although the applicant withdrew from the AME agreement, and that the correct procedure would have been to go through the second opinion doctor under 4062(b), he concluded that the goal of this statute was met since there were two second opinions. The Judge then awarded the surgery recommended by the treating doctor.

This matter was Appealed and the WCAB reversed turning to the ACOEM Guidelines and denied the surgery pursuant to the putative AME's opinion. The Court of Appeal reversed indicating that the requirements of 4062(b) should be followed since the applicant withdrew from the AME agreement. They found the language of 4062(b) mandatory and suggested that the ACOEM Guidelines did not apply as they did not concern "chronic" conditions. They annulled the WCAB's decision denying the surgery and remanded the case to send the matter to the Administrative Director for the random selection of a second opinion evaluation.

Rodas v. Travelers Casualty and Surety (4/20/07) 35 CWCR 156 (Board panel decision)

Defendant's psychological Qualified Medical Examiner on a cumulative claim running through mid-July 2004, was scheduled for deposition in October 2006 by applicant's counsel. The psychologist advised counsel that he would not appear unless the fee was paid 10 days in advance.

Applicant's attorney wrote to the doctor two days before the deposition indicating that he was only required to pay for the deposition at the beginning of the proceedings and that he intended to do so. The doctor did not appear and applicant moved to strike his reports. The WCJ denied the motion and referred counsel to Rule 10536.

Applicant's attorney sought reconsideration removal, noting that Rule 10536 only applies to AME's and doctors the Board chooses and that applicant was irreparably harmed by the judge's refusal to follow CCP sections 2034.440 and 2034.450.

The Board panel indicated since this was not a final order, reconsideration was inappropriate. The doctor's reports need not be struck from the record but applicant did have the right to take the doctor's deposition and need only pay fees at the beginning of the deposition per the cited CCP statutes.

Romero v. Costco Wholesale (2007) 35 CWCR 186, 72 CCC 824 (significant panel decision)

The applicant sustained an admitted industrial injury and defendants provided medical treatment. However, the defendants objected to some treatment being recommended and advised the applicant in writing of the QME procedure. When the applicant failed to submit a timely request for panel QME the defendant did so and one was provided on May 22, 2006. However, the applicant had obtained an attorney on May 18, 2006.

The attorney and defendant were unable to agree on an AME and the defendant selected from the May 22 panel a QME. The applicant however had changed treating physicians to a chiropractor and asserted that she was entitled to a new panel comprised of chiropractors as apposed to orthopedic surgeons.

The administrative director refused to submit a panel of chiropractors and the applicant filed a Petition for the WCAB to obtain such a panel.

The Judge found that the original panel had become inappropriate and ordered the medical unit to provide a new QME panel.

The defendants Appealed.

In its decision the WCAB held that the applicant had not received a comprehensive medical evaluation unless the employee attends and participates in the evaluation. If the applicant never attended and participated in the examination by the designated QME she changed from an unrepresented worker under Labor Code Section 4062.1 to a represented worker under 4062.2. Therefore, she was not precluded from requesting a new QME panel under the latter section.

Wixom v. City of Concord (2007) 35 CWCR 217

Applicant worked for Concord from 1991 to 1997 and from Livermore from 1998 to late 1999. She claimed two separate cumulatives to her arms from these employments.

Concord retained a rehab representative to determine whether she would benefit from services. A work hardening expert hired by the rehab counselor found that applicant was unable to participate in sustained retraining and unable to work.

The case was tried over several hearings over the years. The rehab counselor was on call for each hearing but testified only at the last. Applicant was also seen by a neurologist who apportioned a substantial part of her disability to nonindustrial vehicle accident.

The judge found applicant's Concord employment caused 16% permanent disability and Livermore employment caused 7% permanent disability. Concord was held liable for 50% of the rehab counselor's charges.

Applicant petitioned for reconsideration, contending error in that only 50% of those charges were awarded and that the judge had ignored case law on Labor Code Section 5811. Recon for further study was granted.

The Board panel felt that each of the defendants should be liable for half the costs. Section 5811 allows for reimbursing applicants for costs to prove a contested claim. An applicant may recover costs though the claim itself may not be successful. Her ability to a benefit from rehab is an issue which is properly brought before the Board in arriving at a permanent disability rating.

Costs under section 5811 are discretionary. Because applicant was claiming total disability, it was reasonable for her to obtain expert testimony about her employability in the open labor market. The expense for the rehab counselor's testimony to be shared between the two claims.

This case comes up under the old rating schedule but has relevance to the under the new rating schedule too. Vocational testimony is allowable in dealing with diminished future earning capacity issues. For example, see Costa v. SCIF (2006) 35 CWCR 12, 71 CCC 1797 (en banc). One very large question these days in our system is how such testimony is going to be integrated with the current rating schedule.

MEDICAL TREATMENT

Davenport v. Travelers Property and Casualty Company (2007) 35 CWCR 58 (WCAB panel decision)

The applicant sustained an admitted injury to her back in 2003. She did not lose any time from work but had extensive chiropractic treatment and an MRI showed a disc herniation.

On November 30, 2003 the treater indicated in a report that he “intended” to find her disability permanent and stationary that she had a flare-up of her symptoms in August or September.

The matter proceeded to hearing and the WCJ found that the injury had caused 23% permanent disability using the old schedule.

The Judge also awarded certain species of medical treatment.

The defendant appealed contending that the use of the 1997 schedule was in error because the applicant’s disability was not permanent and stationary until 2005 and that if an unrepresented employee disputes Utilization Review determinations a panel QME must be obtained to resolve that dispute.

Board panel agreed with the defendant citing the *Aldi* case that the 2005 schedule applies to pre 2005 injuries when the requirements of 4660(d) are not met. The treating physician’s report in November did not qualify under any of the exceptions because it was not substantial evidence of permanent disability existing before 2005. That issue was overturned and the matter was remanded back to the WCAB level for further proceedings.

With respect to the medical treatment issue the panel emphasized that when an unrepresented injured worker disputes a Utilization Review Determination, the panel QME process must be gone through. This was not done in this case so the matter was remanded on that issue as well.

Henkel v. State Compensation Ins. Fund (2007) 35 CWCR 188

In a panel decision the Board that held a need for non-prescription pain medication or anti-inflammatory medication is enough to support an Award for future medical care.

The applicant sustained an admitted injury and the QME indicated in his report that the applicant did not need any medical treatment but stated that the applicant can “now treat his symptoms with non-prescription pain medication or anti-inflammatory medication.”

The parties executed a Stipulation on all issues except for the need of medical treatment . This was submitted to the Judge for decision who awarded future medical care. The defendants sought reconsideration contending that the new need for over-the-counter medication does not justify an Award of medical treatment.

The Board panel however affirmed the Judge’s decision indicating that Labor Code Section 4600 provides that medical treatment included medicines with no limitations to prescription drugs. Accordingly it was enough to support an Award.

Hodgman v. WCAB (2007) 155 CA4th 44, 35 CWCR 259,72 CCC 1202_____

The 2nd District Court of Appeal has overturned a WCAB decision limiting reimbursement to the injured worker's mother for her care of her severely disabled son. The Board had only allowed reimbursement for treatment which was not duplicated or duplicative of what a licensed medical professional could provide. The court based its decision on the terms of a compromise and release which specifically stated that the mother could be paid for duplicative of care. Thus, the issue of whether such care in general was reimbursable was left open.

Applicant's October 1998 injury left him with severe physical and cognitive problems and months later his mother was appointed guardian ad litem and trustee before the Board and the following year was appointed conservator of his estate in Superior Court.

In 1989, doctors advised the mother that she should be aware of the nature and extent of her son's injuries since she would be the primary person making decisions about his care. She started doing research, attended all medical appointments, interacted with the doctors, checked on attendant care, medications, arranged for all equipment and supplies, all on the doctor's recommendation. The case manager testified that her involvement was vital as she was the only person capable of making informed consent decisions. She apparently logged medically related services chargeable to the comp case separate from nonmedical activities which were charged to the conservatorship.

In 2000, with a great deal of dispute about what would be covered, a C&R was drafted which covered expenses through the end of 1999 and also indicated that “duplicate services” were defined as not including situations where the same issue is handled by two persons, such as when the guardian and the case manager attended appointments jointly because it was necessary to do so to keep informed on the patient’s situation.

Defendant stopped making payment to the mother in 2005 and the issue came before the Board. The judge thought that all services were completely within the conservatorship and were not related to medical care. The judge noted that applicant lives in a facility where he gets all physical assistance he needs and a doctor is also available to monitor his treatment.

On recon, the Board allowed her to be reimbursed for services which were not covered by the conservatorship and which were not duplicative of those which a health care professional could provide. She appealed.

The Court of Appeal panel felt that medical care could be rendered by a lay person and not just limited to licensed practitioners. Monitoring and managing her son's health care needs qualifies as medical care under section 4600. Apart from its general comments, the court focused on the compromise and release language, indicating that care giving services were to be deemed compensable even if they did duplicate those performed by the nurse case manager.

The carrier was hit for penalties and attorney's fees because the court felt the agreement was not ambiguous.

Most important here was the discussion about what activities would be deemed to duplicative and no clear boundary is drawn. The mother and the nurse case manager both attending medical appointments might very well not be looked at as duplicating each other, while perhaps the mother changing a dressing after it was done by the nurse five minutes before would be duplicate activity. The line here is very hard to draw in what are frequently expensive, catastrophic cases.

Schryer v. Southern Calif. Edison (8/29/07 , SBR 187767) Board panel decision

Applicant injured his right elbow while working as a lineman for the defendant on 12/3/88. He initially treated with a medical doctor and then changed care to a chiropractor on an as needed basis.

In late October 1991 he received a 9-3/4 % PD award and further medical care. The chiropractor treated both arms until March 2006.

In summer 2005, defendants used a chiropractic consultant who would not authorize further chiropractic care because "insufficient outcome measures and pertinent exam findings," and failure to meet the criteria of the ACOEM guidelines.

Applicant objected and went to a chiropractic QME who indicated that the ACOEM guidelines are not a good resource for proper treatment for chronic conditions, especially regarding tendinitis or epicondylitis. The Qualified Medical Examiner pointed to the Mercy guidelines as allowing for chiropractic care and, under the circumstances, recommended one office visit every two to three months.

Defendant denied treatment in September 2005 without mentioning the Qualified Medical Examiner's report and actually advising applicant to go through a Qualified Medical Examiner process.

In October 2005 the defendant's medical director further denied chiropractic care with the treater without mentioning the QME report.

An expedited hearing took place in January 2006 with some testimony and then a further hearing occurred in late August 2006 with the defendant's chiropractic consultant testifying that the Mercy guidelines were not generally accepted and the treatment was not consistent with the ACOEM guidelines.

The judge issued his award in late August 2006 finding treatment required for both of applicant's arms. Defendant challenged the judge's holding that the UR process was inappropriate in chronic disability cases, and that UR is inappropriate when there has been an award of future medical care.

A Board panel decided that the ACOEM guidelines may not be ignored following an award or further care when meet for treatment as disputed. Medical treatment per section 4600(b) and these are presumed correct per section 4604.5(c).

The panel observed that there was no consensus on whether ACOEM guidelines were applicable to treatment for anything other than acute and sub-acute stages of an injury. The panel also noted that it was not appropriate to indicate that the ACOEM guidelines never applied beyond 90 days of the date of injury nor that the guidelines entirely govern such chronic care.

The panel analyzed to the ACOEM guidelines to indicate that in certain chapters, the guidelines do attempt to deal with treatment for injuries which are chronic and that the guidelines include general principles which remain applicable regardless of the stated period of recovery. Every case must be determined on its own merits. Medical records need to be reviewed to determine the stage of recovery, treatment already attempted and its results, whether the recommended treatment falls within the ACOEM guidelines and if the guidelines contain a disapproval of treatment, whether a variation is required.

In this instance, since the defendant never dealt with the panel Qualified Medical Examiner who approved the treatment recommendations of the primary treating physician and it was unclear why the denials did not even mention his opinions. On that basis, further treatment as described by the Qualified Medical Examiner was approved.

The bottom line here for the Board is the view that the ACOEM guidelines could be applicable to treatment even pursuant to a prior award and can apply to treatment of chronic conditions.

Stokes v. California Department of Mental Health (2007) 35 CWCR 213, 72 CCC 996 (significant panel decision)

A board panel has rescinded the trial judge's disallowance of an ambulatory surgery Center's lien because the lien claimant did not have a fictitious name permit issued by the Division of Licensing of the Medical Board of California [DLMBC] before providing the services it was attempting to obtain reimbursement

since the panel felt the record was unclear as to whether the Center was rendering services as a "clinic" or as an "outpatient setting."

Applicant hurt her spine and shoulders of August 2002. She received outpatient surgery at the Ambulatory Surgery Center of Pomona. Defendant paid lien claimant what it deemed appropriate under the OMFS and Medicare guidelines and lien claimant sought an additional \$44,500. All issues with applicant were resolved and the only one left was the lien claim. The sole issue for trial was whether the surgery Center was properly licensed per Business and Professional Code sections 2285 and 2415 and if not, whether it was entitled to any reimbursement.

The matter was submitted on documentary evidence, including a Los Angeles County fictitious name statement, and the crediting letter from the Accreditation Association for Ambulatory Health Care (AAAHC) and a Pomona city business license. The judge disallowed the lien for failure to have a fictitious name permit issued by the DLMBC.

The lien claimant, on reconsideration, argued that it was only claiming "facility fees" and not "professional fees" and therefore not required to get a permit from the DLMBC and that it possessed all necessary licenses and accreditations required of a Surgery Center.

In his report and recommendation, the judge advised that according to B&P Code section 17900(a)(3), the surgery Center was operating under a fictitious business name because it was using a name other than that in its articles of incorporation. B&P Code section 2285 calls it unprofessional conduct to use a fictitious name without obtaining a permit per section 2415, which indicates any physician who is a professional corporation and wants to practice under anything other than the corporate name must obtain and maintain a fictitious name permit from the DLMBC. Title 16 CCR section 1350.2 further indicates that no licensed person can provide professional services using a fictitious name unless they obtain the appropriate permit from the DLMBC.

The panel indicated that the record was inadequate to determine whether the surgery Center was claiming to or provided medical treatment to this applicant as a "clinic," in which case it needed the appropriate permit from the DLMBC or as an "outpatient setting," in which case is only needed proper accreditation from an agency recognized by the MBC. A clinic that provides medical treatment must be separately licensed by the DLMBC, while an outpatient setting does not provide medical treatment although surgeries may be performed there, an outpatient setting does not need licensing from the MBC if accredited by an approved accreditation agency. Health & Safety Code sections 1200, 1248, 1248.1 and 1248.8 define these entities.

Lien claimant can argue that it didn't have a fictitious name permit for the DLMBC and would claim it was not required to because it was an accredited outpatient setting. However, in its recent petition it stated that it had provided "medical treatment to the applicant." The panel couldn't determine from the record whether the lien claimant was claiming to be a properly accredited outpatient setting or whether it operated as a clinic, providing medical treatment, in which case it needed to have a license and the permit from the

DLMBC. If an outpatient setting, the record was unclear as to whether the AAAHC accreditation properly applied to it.

The case was returned to the trial level to allow for continued confusion and consternation to run rampant through the comp system in Santa Barbara and elsewhere.

Sutton v. WCAB (2007) 35 CWCR 264, 72 CCC 1227

The 5th District. Court of Appeal has applied ACOEM guidelines to chiropractic care following a precautionary medical award issued in 1985 for a 1983 injury.

Disputes sporadically broke out over the years as to whether treatment was needed and then July 2006 applicant demand an expedited hearing for ongoing chiropractic care for visits once or twice a week during flareups which occurred about once a month

The trial judge declined to accept reports of defendants chiropractor's who are not licensed in California (and presumably were part of the utilization review process). He awarded six months of chiropractic care on an interim basis and ordered the parties to develop the record further on what the most effective future care would be for the injury. Defendant filed a recon and the panel indicated that applicant had an award and under section 4600(b), it was subject to ACOEM.

Applicant filed a writ. The Court of Appeal determined that the Board's decision was an interim one about entitlement to further care but that since it made a final determination on the use of the ACOEM guidelines, it was in essence a final order.

The court found that Labor Code Section 4604.5(c) applied regardless of the date of injury. Applicant's sole recourse was to prove that the ACOEM guidelines were inappropriate and needed to provide other evidence-based medical to rebut them.

As a bone to applicant, the court indicated that since the injury occurred before 1/1/04, the limits on the number of chiropractic visits did not apply.

PENALTIES

Jackson v. State Compensation Insurance Fund (2007) 35 CWCR 215

Applicant was hurt in June 2004. In April 2005 a chiropractic QME evaluated her. He billed SCIF \$750 for the evaluation. Five months later, defendant paid the \$750 without interest or penalties. The QME determined to pursue this issue after unsuccessfully trying to collect from the defendant. He got help from the Board which scheduled a status conference for early March 2007. Defendant did not attend. It sent the QME a check for penalty and interest after the conference date. A formal hearing with the issue of sanctions was set three weeks later on 3/27/07. Defendant once again did not appear. The judge served a notice of intention to submit and a proposed order of sanctions. Defendant objected to the order but not to the submission. Thereafter, the judge served findings and order directing defendant to pay \$500 to the QME as a sanction.

Defendant sought reconsideration arguing that its failure to attend the conference was not a bad faith action per Labor Code section 5813. Because it timely paid the QME, then the sanction order was not justified by the evidence, among other things. The judge pointed out that Skiff admitted it was five months late in paying the bill and did not pay penalty or interest until much later. It never raised the issue of timely paying the QME when the notice of intention was issued in late March 2007. The judge indicated that defendants' unilateral decision that it had resolved the issue was erroneous because the QME was still trying to collect his penalty before asking for the status conference in March 2007 and was ignored. Judge further pointed out that WCAB Rule 10561 defines a bad faith action as resulting from the willful failure to comply with a statutory or regulatory obligation. Imposing sanctions was appropriate here. QME should have been paid as interest and penalties automatically but was not. The Board panel adopted the judge's reasoning and denied reconsideration.

Kastning v. Allied Distributing Co. (2007) 35 CWCR 245

In another penalty case the applicant sustained an admitted industrial injury that eventually went to a Findings and Award in April 2004 which included the need for further medical treatment.

The applicant submitted mileage requests to the administrator. The claims administrator delayed paying. By Findings and Award in May 2006 the Judge awarded penalty for the unpaid mileage. However subsequently the defendant continued to delay mileage reimbursement.

The case went to hearing again in March 2007 and the Judge issued a Finding indicating that the defendant was liable for a 25% penalty on top of the previous penalty for failure to pay mileage for August of 2005(pre-dating the earlier decision) a 25% penalty for failure to pay mileage subsequently and sanctions in the amount of \$2,500. Applicant's attorney was also allowed a fee of \$1,047.50 under Labor Code Section 5814.5 for unreasonable delay.

The defendant Petitioned for Reconsideration arguing that the penalty for the August 2005 delay was not justified, the sanctions were unreasonable, the penalty for the delay of the 2006 mileage was excessive and the attorney's fees awarded under 5814.5 were baseless.

The WCAB granted reconsideration and indicated that the sanctions should be reduced and that the attorney's fees should be deferred.

As to the sanctions the panel concluded that sanctions were appropriate, but since this was the first time that sanctions had been imposed in this case that \$1,000 was more appropriate than the full \$2,500. They also determined that the Award of attorney's fees was not adequate because it was not based on an itemized Petition so they ordered that the attorney fee issue was to be deferred.

They reaffirmed that pre-2006 Award penalties had already been addressed by the 2006 Award that was never appealed.

Vega v. Barrett Business Services (2007) 35 CWCR 244

The applicant sustained an admitted injury. There were three formal hearings at which an interpreter was present and the case was eventually resolved by a Stipulated Findings and Award which was approved in July 2006. Before that date the interpreter filed a lien for her services however the defendant did not pay that until March of 2007. Penalties and interest were not included.

About four days before the lien was paid the lien claimant retained an attorney to pursue her claim and a Petition for Sanctions was filed under 5813 and penalties under 5814, 5811 and 4622.

The case went to Trial and the Judge found that defendant engaged in bad faith delay tactics not making payment on the lien for reasonable interpreting service at the WCAB hearings in this case. The Judge awarded attorney's fees for 11.3 hours totaling \$2,542.50. They further ordered penalties of 10% of interest under 4620 and 4622.

Defendants sought reconsideration claiming that lien claimant is not entitled to penalties under 4620 and 4622.

The workers' compensation Judge conceded that there was merit in the defendants arguments in that 4620 and 4622 cover only med-legal expenses and interpreter fees are not med-legal expenses. He recommended that the Board grant reconsideration for the sole purpose of rescinding findings on this issue. The recommendation by the Judge was adopted by the Reconsideration Unit disallowing the penalty Award. Presumably however, the attorney's fee Award remained intact.

PERMANENT DISABILITY

Audiss v. City of Rohnert Park (2007) 35 CWCR 123

The applicant sustained an admitted injury to her right wrist. The applicant received treatment and the treating physician issued a permanent and stationary report which was received on July 6. Three weeks after its receipt the defendant mailed the applicant the appropriate form while she was still working at her regular job. She accepted the offer. Stipulations were prepared consistent with a 15% reduction and permanent disability pursuant to Labor Code Section 4658(d). The WCJ refused to approve it and rather than decreasing the Award the Judge increased the Award finding that the defendant had not timely provided the applicant the offer of regular work.

The panel indicated that the defendant had complied with the requirements of 4658 in that shortly after receiving the final permanent disability report they issued the notice. The fact that they did not issue the notice after receiving a permanent and stationary report that did not discuss permanent disability was not dispositive.

Moreover, they indicated that the timing of an employer's offer of work is not dispositive when the employee has been continuously employed at his or her regular job. Continuation of regular job was thought to be equivalent to an offer of work.

Baglione v. AIG (2007) (en banc) 35 CWCR 21

In a case involving whether or not to use the old or new Schedule the Board eventually concluded that the old Schedule would apply.

The applicant had an industrial injury in June of 2003 and on June 18, 2004 had a QME evaluation. That evaluation, however, did not discuss permanent disability.

Eventually the parties agreed to an AME and in a report of April of 2006 the doctor wrote that the applicant's disability was permanent and stationary in April of 2005.

At trial the judge originally found 10% permanent disability based on the new schedule because there was neither a report from a treating physician nor a comprehensive medical legal report indicating the existence of permanent disability prior to January 1, 2005.

The Board in a four to three decision indicated that under §4660(d) the comprehensive med legal report need not necessarily indicate the existence of permanent disability. There only need be a "comprehensive medical legal report" and therefore remanded the decision back to the judge to determine the applicant's PD using the 1997 Schedule. (It is likely this case will be appealed)

Baglione v. AIG (2007) 35 CWCR 121, 72 CCC 444 (en banc) (Baylione II)

After a complicated procedural battle the Board ultimately issued in a ruling on Labor Code Section 4660(d).

The applicant did sustain an admitted industrial injury in 2003 and a QME prepared a comprehensive med-legal report in June of 2004 that did not discuss permanent disability.

Later on there was an AME who indicated that the applicant's condition had become permanent and stationary in April 2005.

After Trial the WCJ applied the 2005 schedule for rating permanent disability because none of the exceptions of 4660(d) were applicable.

The applicant filed Reconsideration indicating that his permanent disability should have been rated under the old schedule because a comprehensive med-legal report existed before January of 2005.

In a 4-3 decision the Board held that because a comprehensive med-legal report issued in this case before 2005, the 1997 schedule applied even though that report did not indicate the existence of permanent disability.

However, before the decision became final one of the Commissioner's term expired and a new Commissioner was appointed to replace him.

During this time the defendant timely sought Reconsideration of the Board's decision, and argued that the 2005 schedule was applicable in this case.

The WCAB granted the Petition indicating that they were not bound by their prior opinion since a timely Petition for Reconsideration was filed. Pursuant to that Reconsideration the Board may rescind, alter, or amend prior decisions. They specifically found that the principle of stare decisis did not apply in this case because a timely Petition for Reconsideration was filed. Hence the Board was free to reconsider its prior decision and reach a different conclusion.

They found the change in Board membership did not prevent them from doing so.

In examining the facts of the case the Board specifically found that since the comprehensive med-legal report did not indicate the existence of permanent disability, that one of the exceptions of 4660(d) was not met. Hence, the new schedule applied.

The dissenting opinion argued that the language of 4660(d) meant that the comprehensive med-legal report need not indicate the "existence of permanent disability", rather that quoted language only applied to a report of the treating physician.

Chang v. WCAB (2007) 153 CA4th 750, 35 CWCR 209, 72 CCC 921

A cumulative claim pending in 2004 which became permanent and stationary at 2005. None of the exceptions to section 4660 (d) seem to apply. Reconsideration was denied. The Court of Appeal was not impressed with arguments that the results of SB 899 were the granting of wage profits to the insurance industry. The court advised the appellant that it was not a legislative committee and did not appreciate being preached to. The intent of the Legislature was clear as to cutting back costs and expenditures in the comp system.

City of San Diego v. WCAB (Brooks) (certified for non-publication)

The Court of Appeal addressed another case of whether the 1997 or 2005 schedule for permanent disability would apply.

In this case the applicant, a fire captain, tested positive for Hepatitis C in 1999. He filed an Application in 2001 and a med-legal evaluator issued a report in June 2001 indicating that it was reasonably probably that work place exposure existed and that applicant's condition was permanent and stationary but had no subjective factors of disability but did have an objective factor, i.e., the Hepatitis C. The applicant had no work restrictions. The QME found no permanent disability.

Nothing further was done on the case until 2005 when the QME issued a supplemental report stating that the applicant's permanent impairment should be rated under the AMA Guides on the basis of the 2005 schedule which treats Hepatitis C as a 25% whole person impairment.

In this case the Judge held that the new schedule applied and the WCAB denied defendants Petition for Reconsideration.

The Court of Appeal affirmed the WCAB, finding that the original report of the QME clearly existed before 2005. The question was whether or not the report indicated the existence of permanent disability thus requiring the application of the old schedule.

Here they concluded that the language of 4660(d) indicated that the comprehensive report of the QME had to indicate the existence of permanent disability. (Citing the *Costco Wholesale Corp. v. WCAB(Chavez)*). Hence, they concluded that the original QME report back in 2001, which indicated that there was no permanent disability, did not trigger the use of the old schedule and that the new one controls the rating.

Costco Wholesale Corp. V. WCAB (Chavez) (2007) 151 CA4th 148, 35 CWCR 147, 72 CCC582

On 5/23/07, the 1st District Court of Appeal, division Four, strictly construed the exceptions to uses of the new rating schedule for pre 2005 claims. Thus, the court made a decision consistent with the Board en banc

decision in Baglione II and Pendergrass II (35 CWCR 121, 72 CCC 444 and 35 CWCR 124, 72 CCC 456, respectively).

This Costco warehouse worker had an injury to the right side and low back on 6/5/04. On 9/24/04, a panel selected evaluator found that applicant was permanent and stationary. He mentioned some work restrictions but thought applicant might be upgraded from those restrictions and that he should stabilize within three to four months. The parties used a chiropractic Agreed Medical Examiner, who reported on 10/25/05 that applicant was permanent and stationary at that time.

The trial judge felt that the Qualified Medical Examiner report of 9/24/04 was a comprehensive medical legal evaluation existing before 1/1/05 and applicant got 52% permanent disability under the old system. The Commissioners split on reconsideration. The majority (Caplane and O'Brien) felt that the said 4660(d) exception applied when there was any comprehensive medical legal report before 1/1/05. Dissenter Cuneo felt the comprehensive medical legal report must show permanent disability for the old schedule to apply.

The Appellate Court panel could find no rational basis for the Legislature to include a comprehensive medical legal report in the statute unless it was tying it to a requirement that permanent disability be described in the report. The court went on, in dictum, to knock out any argument that the notice requirement mentioned in section 4660(d) arose when temporary disability started in October 2004 rather than when it ended in late June 2005. The court found legislative intent to bring as many cases as possible under the new rating schedule.

Davenport v. Travelers Property and Casualty Company (2007) 35 CWCR 58 (WCAB panel decision)

The applicant sustained an admitted injury to her back in 2003. She did not lose any time from work but had extensive chiropractic treatment and an MRI showed a disc herniation.

On November 30, 2003 the trier indicated in a report that he "intended" to find her disability permanent and stationary that she had a flare-up of her symptoms in August or September.

The matter proceeded to hearing and the WCJ found that the injury had caused 23% permanent disability using the old schedule.

The Judge also awarded certain species of medical treatment.

The defendant appealed contending that the use of the 1997 schedule was in error because the applicant's disability was not permanent and stationary until 2005 and that if an unrepresented employee disputes Utilization Review determinations a panel QME must be obtained to resolve that dispute.

Board panel agreed with the defendant citing the *Aldi* case that the 2005 schedule applies to pre 2005 injuries when the requirements of 4660(d) are not met. The treating physician's report in November did not qualify under any of the exceptions because it was not substantial evidence of permanent disability existing before 2005. That issue was overturned and the matter was remanded back to the WCAB level for further proceedings.

With respect to the medical treatment issue the panel emphasized that when an unrepresented injured worker disputes a Utilization Review Determination, the panel QME process must be gone through. This was not done in this case so the matter was remanded on that issue as well.

Energetic Painting & Drywall v. WCAB (Ramirez) (2007) 153 CA4th 633, 35 CWCR 209, 72 CCC 937

Neck and back injury in 7/04 with temporary disability from 7/13/04 to 3/24/05. The trial judge followed Pendergrass I because temporary disability started in 2004. Per Costco, the decision was overturned.

Gilliland v. Safeway (2007) 35 CWCR 271, 72 CCC _____

Applicant injured her neck on 5/15/99 at work for the employer. She was overpaid PD advances and ultimately stipulated to 10% permanent disability. The stipulations also indicated, "Per agreement defendant has \$16,789.40 credit against future PD"

In late January 2003, applicant had a low back injury as a cashier for the same employer. A QME found that she had 32% permanent disability after adjustment but defendant did not advance any PD but claimed credit for that \$16,789.40 overpaid in the earlier case.

The trial judge found the 32% PD and allowed the defendant the full credit noted above.

The Board panel overturned the judge's decision. The neck case stipulation did not say that it applied to all of applicant's future claims. If she had claimed new and further disability related to the 1999 claim, the credit would clearly apply.

The panel observed that, under Labor Code section 4909, voluntary payments may be allowed as a credit but only at the discretion of the Board. Although the judge had thought that the spine was a single region of the body per section 4664 (c), that statute is irrelevant here. The court said that there was no authority to support credit for overpayment of benefits for an injury involving a particular body part against liability for benefits for a separate injury to a different body parts. The panel amended the findings and award to allow the PD without deduction of the credit at all.

[Perhaps the panel's concern was more practical than purely legalistic. If the credit were applied, applicant would wind up recovering under \$400 for the remainder of her PD versus a bit over \$17,000.]

Hernandez v. USF&G (5/4/07) 35 CWCR 155 (Board panel decision)

Applicant had a right knee injury in July 2004. Defendant carrier paid temporary disability through 3/7/06.

The primary treater reporting in late October 2004 diagnosed a torn meniscus and decided applicant was temporarily disabled. In 2006, an AME found applicant permanent and stationary and described permanent disability factors.

The trial judge, following earlier decisions in Baglione and Pendergrass (a.k.a. B I and PI) found that since temporary disability began before 1/1/05, this was an old schedule case.

The Board panel indicated that the earlier Baglione and Pendergrass decisions had been rescinded and reversed in their sequels-Baglione II (35 CWCR 121, 72 CCC 444) and Pendergrass II(35 CWCR 124, 72 CCC 456). Because Board panels are obligated to follow en banc decisions per Rule 10341, BII and PII were now the law of the land.

Since the parties stipulated that temporary disability continued through 3/7/06, the new rating schedule applied. The panel did not decide whether the treaters's October 2004 report was a comprehensive medical-legal report for another exception noted in section 4660(d).

Note that two of the panel commissioners, Ms. Caplane and Ms. Murray, dissented in BII and PII, but obviously did not find themselves a way around Rule 10341.

Note also SCIF v. WCAB(Echeverria)(2007) 146 CA 4th 1311, 35 CWCR 1, 72 CCC 33 which held that a medical report written before the disability was permanent and stationary is not one indicating the existence of permanent disability and Trader Joe's v. WCAB(Evets)(2007) 35 CWCR 51, 72 CCC 204, the court in an unpublished decision said the new schedule applied because no medical reports before 2005 indicated the existence of permanent disability although they may describe loss of motion and nerve damage.

HSR, Inc. v. WCAB (Mariscal) (2007) 35 CWCR 262, 72 CCC 1211

Applicant was injured in late October 2004. He started getting temporary disability in early November 2004 through mid-January 2005. On 12/22/04, his treater checked the "yes" box on the form applicant's attorney muster provided in answer to the question of whether there will be permanent disability.

The trial judge felt that the check the box report was substantial evidence of the existence of PD.

The 6th District Court of Appeal disagreed. The “yes box” report supplied no history, did not mention case facts, diagnoses or other requirements of WCAB Rule 10606. The court advised that medical opinion is not substantial evidence if it is based on an inadequate history or speculation. But it must also indicate the reasoning behind the doctor's opinion.

The court rejected applicant's contention that quote "the existence of permanent disability need be no more than a brief suggestion, any sign or an inference." [Apparently poetry or telepathy is not substantial evidence.] The court directed that the case be rated under the new schedule.

Joiner v. WCAB (2007) 35 CWCR 210, 72 CCC 943 (nonpublished)

The applicant's attorney argued that a literal reading of section 4660 (d) meant that all injuries before 1/1/05 needed to be rated under the old schedule since the new rating schedule and system did not come into effect until the beginning of January 2005. The court rejected that argument out of hand. It also rejected an argument that since there were doctor reports in 2005 that applicant was permanent and stationary retroactively to 2004, the old schedule should apply.

Lyngso Garden Materials Inc. v. WCAB (Ruiz) (2007)

The applicant sustained an admitted cumulative back injury and was paid temporary disability from 2004 into January of 2006 having become permanent and stationary in August 2005.

At Trial, testimony was given by a vocational rehabilitation counselor on the issue of diminished future earning capacity but the Judge applied the 1997 schedule and awarded costs under 5811 for the vocational rehabilitation expert testimony. The defendant sought reconsideration on both issues. This was denied.

The Court of Appeal, First District, accepted the Appeal and citing *Chavez and Pendegrass II* found that the 2005 schedule applied. However, on the vocational rehabilitation expert cost issue they indicated that since the 2005 schedule was in issue, future earning capacity was an issue. The fees associated with the vocational rehabilitation expert testimony were properly awardable.

Magana v. Wausau Business Ins. Corp. (2007) 35 CWCR 242

The applicant had an admitted injury in February 2007. After a QME evaluation found a 2% impairment of the whole person the case went to Trial. In addition to the admitting QME report the defendants called a vocational consultant who testified that the applicant's disability would not result in any future wage loss but applicant's expert indicated that the applicant had sustained a 27% loss of future earning capacity.

The WCJ obtained a recommended rating on the QME's findings at 12% and issued an Award consistent there with.

The applicant filed a Petition for Reconsideration. The panel affirmed the Judge's decision.

In its decision the panel indicated that the schedule is prima facie evidence of the percentage of permanent disability attributed to the injury. The panel indicated that diminished earning capacity is but one of several factors to be considered in awarding permanent disability and that the applicant's expert failed to demonstrate that the applicant's diminished future earning capacity was not appropriately reflected by the FEC rank 2 contained in the permanent disability schedule. However, they pointed out that the applicant's expert gave testimony before the recommended rating was formulated and thus did not show why the recommended rating did not give adequate consideration to the DFEC.

Minatta Transportation v. WCAB (Lanning) (2007) 35 CWCR 209, 72 CCC 950 (nonpublished)

Same appellate panel as Costco. The court found temporary disability closure in 2005 as dispositive of the case rather than temporary disability commencement in 2004.

Pendergrass v. SCIF (2007) (en banc) 35 CWCR 26, 72 CCC 95

In another four to three *en banc* decision the WCAB found that the injured worker's permanent disability should be calculated by the use of the 2005 Rating Schedule.

In Pendergrass, the applicant had an injury to his right leg on June 29, 2004 and benefits were picked up including temporary disability through July 19, 2005.

The case went to trial on the primary issue of whether or not applicant's permanent disability should be calculated under the 1997 or 2005 Rating Schedules and the judge found that the 2005 Schedule should apply.

The applicant filed a Petition for Reconsideration contending that his permanent disability should be calculated under the old Schedule because the defendant had been required to provide the Notice under §4060 when temporary disability commenced.

Focusing on the language in §4660(d), which provides the exceptions to using the new schedule, the phrase "duty to provide the Notice required by §4061" was examined closely. Defendants argued that the duty to provide that Notice does not come into effect until temporary disability ends. However, applicant argued that the duty to provide the §4061 temporary disability Notice occurs as soon as the first date of compensable temporary disability occurs. As soon as you have to pay temporary disability a duty will arise for you to give a §4061 Notice when you stop it. Somewhat amazingly they distinguish between when the

duty arises and when it is required to be executed. The duty arises when the first payment of temporary disability is made but it is executed when the last payment is made. Accordingly, they returned the case back to the trial level for the applicant's permanent disability to be calculated under the 1997 schedule.

Given the vigorous nature of the dissent and some contradictory findings in other cases we expect this issue to continue to be argued. Including the Vera v. WCAB and City of San Diego v. WCAB (Brooks) currently pending in the Fourth District.

Pendergrass v. State Compensation Insurance Fund (2007) (en banc) 35 CWCR 124, 72 CCC 456 (Pendergrass II)

Once again the WCAB in an *en banc* decision reversed its prior *en banc* decision after a change in commissioners.

In this case the applicant sustained an injury to his right leg on June 29, 2004 and benefits were picked up including temporary disability through July of 2005.

The case went to Trial and among the issues submitted were whether or not the applicant's permanent disability should be calculated under the new or old schedule. The Judge found that the new schedule should apply.

The applicant filed a Petition for Reconsideration contending that his permanent disability should be calculated under the old schedule because the defendant had been required to provide the notice under 4660 when temporary disability commenced.

In its initial *en banc* decision the WCAB held that the duty to provide the notice required by 4061 arose as soon as you made your first payment of temporary disability. As soon as you have to pay temporary disability a duty will arise for you to give a 4061 notice when you stop it, thus, one of the exceptions to 4660(d) arose and one should apply the old schedule.

However, before that decision became final there was a change in commissioners and the defendant sought reconsideration contending that the 2005 schedule still applied.

The WCAB found that they could reconsider this decision and interpreted 4660(d) to find that the triggering of the employers obligation to provide the 4061 notice attaches with the last payment of temporary disability as apposed to the first. Thus, under 4660(d) the new schedule would apply in this case.

Once again, there was a disseting opinion arguing that the employer is required to provide a temporary disability notice under 4061 when the first payment of temporary disability is made

SCIF v. WCAB (Echeverria) (2007) 146 CA4th 1311, 35 CWCR 1, 72 CCC 33

In a published opinion the Court of Appeal reversed a WCAB decision that applied the 1997 permanent disability Rating Schedule finding that the 2005 schedule would apply.

The applicant sustained an admitted injury to his back and ankle in July of 2004. The treating physician reported temporary disability in a series of reports through late 2005.

However, in November of 2004 the applicant's attorney wrote to the treating doctor asking him to "please advise by merely signing and dating this letter if you believe permanent disability, as the term is now defined,

is a reasonable medical probability as a result of your patient's industrial injury." The doctor countersigned that letter on December 15, 2004.

A subsequent AME exam found the applicant was permanent and stationary on June 16, 2005.

At trial, under the new schedule, it was found he had 18% permanent disability and under the old schedule he had 45%.

The judge awarded 45% noting the November 2004 letter countersigned by Dr. Morales.

The defendants appealed and the WCAB denied Reconsideration.

The defendants filed a Writ contending that the November 15, 2004 letter was not a report by a treating physician but that those were merely the words of the applicant's attorney that the doctor countersigned.

The Court of Appeal agreed with the defendant's position finding that the treating doctor's single sentence statement was inconsistent with the rest of his reports which discussed continuing range of motion problems throughout his examination and declaring the applicant temporarily disabled. There was no reasoning to support the comment and found it was not substantial evidence. The original Opinion was initially unpublished but in January of '07 the Court ordered it Certified for Publication.

SF Marriott v. WCAB (Yamat) (2007) 35 CWCR 210, 72 CCC 1103 (nonpublished)

Temporary disability started in 2002 and ended in 2005. The Court rejected the argument that the new rating schedule was only meant to go into effect on 1/1/05. Any right applicant has to benefits depends solely on statute and can be altered even when the matter was pending prior to the new law's enactment. [Bye-bye constitutional argument?] Thus, applicant's argument that section 4453.5, which states that benefit

should be paid under the law in effect as of the date of injury and may not be altered by later statutory changes, is overruled by section 4660 (d), as a specific statute controlling over a more general one.

Trader Joe's Company v. WCAB (Evets) (2007) 35 CWCR 51, 72 CCC 204

In an unpublished opinion the Court of Appeal applied the new schedule where there had been no report by a treating physician indicating the existence of permanent disability before January 1, 2005.

The applicant sustained an admitted injury in January of 2004, involving a crush injury to the right hand with some amputation. The applicant continued to treat through 2004 and further surgery was being contemplated but none of the reports indicated the applicant's condition was permanent. The applicant was released to return to work on March 1, 2005 and a QME report indicated applicant became permanent and stationary as of that date. The case went to trial on the sole issue of which schedule would apply and the judge concluded that the 2005 schedule applied in the absence of a pre 2005 report indicating applicant was permanent and stationary.

The applicant filed a Petition for Reconsideration arguing that the 2004 reports described medical conditions which by their nature would result in permanent disability, i.e., a crush injury to the hand, limited range of motion and nerve damage and that these reports were sufficient to indicate the existence of permanent disability within the meaning of §4660. Based on a Petition for Reconsideration, the judge reissued his award under the 1997 Schedule.

Defendants filed a Petition for Reconsideration which was denied and defendants filed a Writ of Review.

The Court of Appeal reversed, finding that there was no comprehensive medical report and no obligation to give notice under §4061 prior to January 1, 2005 so that the 1997 Schedule could be applied only if the report by the treating physician indicated the existence of permanent disability was prepared before 2005. The Court emphasized that this does not mean that a percentage of disability must have been determined prior to 2005 but it does mean that a "qualifying report must at least state that the applicant is or will be permanently disabled or, at a minimum, describe an injury that necessarily will result in permanent disability." They found that neither reports met that test.

University of California San Francisco v. WCAB (Rand) (2007) 35 CWCR 210, 72 CCC 1108 (nonpublished)

A comprehensive medical report was based on a visit in late December 2004, following an injury just a few months earlier. The treating doctor did not issue that report until 1/6/05. It said that prognosis was poor and applicant would ultimately require retraining. The "poor prognosis" language did not reflect the current existence of permanent disability. Further it wasn't issued until 1/05. Applicant also received temporary

disability continuously from 10/18/04 through 7/22/05, some of it wage loss and most of it temporary total disability. The court also rejected the argument and any changes in temporary total disability to temporary partial disability required giving notices. The notice required by section 4061 occurs at the end of temporary disability payments.

Vera v. WCAB (2007) 35 CWCR 233, 72 CCC 1115

The applicant suffered an admitted injury in March of 2003 and temporary disability was paid from March 2003 to February 1, 2007. On April 26, 2004, the applicant's new doctor drafted a new report indicating that the applicant "does currently have the existence of permanent disability" but also indicated that the applicant's condition was not permanent and stationary.

At the eventual hearing the Judge found that the report was sufficient to indicate the existence of permanent disability prior to 1/1/05 and awarded the benefits based on the 1997 schedule.

Defendant filed a Petition for Reconsideration which was granted and in a 2-1 decision the WCAB reversed the decision and held that the 2005 schedule applied. It was indicated that the April 26, 2004 report found permanent disability only on a preliminary basis rather than that permanent disability was in existence prior to January 1, 2007. The dissent argued otherwise.

The Court of Appeal agreed with the Board indicating that the new schedule applied. The Court observed that if the treating doctor described permanent disability prior to 1/1/05 by necessity the impairment would be described under the terms of the old schedule thus the legislature intended the old schedule to apply. When the treating physician prepares a report after the effective date of the statute the permanent disability would be described under the new guides.

The applicant had also argued that the old schedule applies because the employer was required to give notice under 4061 when temporary disability commenced, and this Court in the Fourth District rejected same citing *Chavez, Azizi, Pendergrass* cases.

Washington Mutual v. WCAB (Helm) (2007) 35 CWCR 210, 72 CCC 962 (nonpublished)

A January 2004 treaters report indicated that although applicant was on temporary disability, her "permanent factors of disability remain unchanged." For the court, none of the reports demonstrated actual evidence of permanent disability and the conclusions were unsupported by any reasoning and contrary to an AME report stating that applicant was not permanent and stationary.

Zenith Ins. Co. v. WCAB (Azizi) (2007) 153 Cal. App 4th 461, 35 CWCR 177, 72 CCC 785

The First District agreed with prior decisions in *Costco Wholesale Corp. v. WCAB (Chavez)* and *Pendegrass v. State Compensation Ins. Fund "Pendegrass II"*.

This is another case where the defendants paid temporary disability before 1/1/05 but didn't stop paying it until after 1/1/05. The analysis of earlier opinions indicating that the duty to provide a notice under 4061 arose when permanent disability was first paid was rejected since the last payment of temporary disability was after 1/1/05, the new rating schedule would apply.

PRESUMPTION

Leprino Foods v. WCAB (Owens) (2007) 35 CWCR 151 72 CCC 605 (5th District, nonpublished)

The 5th District Court of Appeal in an unpublished memorandum opinion, found that an employer could not raise the defense of post termination report of injury when he knew beforehand that applicant claimed he had hurt himself. The court also supported the judge in raising the issue of presumption of injury under section 5402, even when neither party raises it at trial.

Applicant was a foreman involved in a series of fights at work on 11/10/04. He fell to avoid being hit by a forklift driven by this coworker. An hour later he reported to his supervisor showing him his bleeding arm and knee. The supervisor would not fill out an injury form and the following day the HR manager met with applicant and the department manager. Applicant advised he has been injured and wanted an accident form. The HR manager suspended him. When he came back the following day as requested, he was terminated. Eight days after the injury and after his termination, applicant filed a claim form for the specific injury on 11/10/06 and for a cumulative period.

The trial judge in September of 2006 awarded applicant ongoing temporary disability and section 132(a) penalty for termination because of his injury. The Board panel agreed with all the awards other than the discrimination one.

The Court of Appeal panel dealt with the 90 day presumption issue under Labor Code Section 5402(a) which had been raised by the trial judge in ruling that defendant had failed to convey denial of the claim in a timely fashion. The court agreed that a statutory presumption must be considered even if the parties do not raise it as an issue, citing Gee v. WCAB(2002)96 CA 4th 1418, 30 CWCR 68, 67 CCC 236. The court was not impressed with the posttermination defense of Labor Code Section 3600(a)(10). His trial testimony of the applicant and the supervisor, defendant knew about the specific injury before it fired him. On the continuous trauma claim, no evidence was presented to show that the injured worker knew or should have known that his pain was related to his job before he was fired.

Muna v. WCAB (2007) 35 CWCR 263, 72 CCC 1219 _____

Applicant had a prior PD award for a 3/19/99 back injury. After later work for a different employer, he filed a cumulative through 11/02. Liability was not denied within 90 days. At a hearing two years later, the parties stipulated that applicant had sustained an admitted cumulative claim through 11/24/02 per Labor Code section 5402, but added "defendant reserves the right to rebut based on later evidence."

Three months later, defendant moved to dismiss the case based on their physician who indicated that applicant's problems all relate to the 1999 specific. Applicant got a Qualified Medical Examiner report about six months later which also indicated that all the disability went back to the 1999 injury.

The trial judge found cumulative injury based on the lack of a timely denial and the presumption.

In her report and recommendation, the judge felt that post-90-day evidence could come in but that it had not rebutted the presumption. The Board panel felt that the reports in question couldn't have been produced within 90 days and that they successfully rebutted the presumption.

The Court of Appeal stated that the stipulation entered into in August 2004 clearly allow the defendant to rebut the presumption based on later evidence. On the substantial evidence question, the court pointed out that applicant had never presented any medical evidence showing that she suffered a cumulative injury and was relying totally on the presumption. Both the treater and the QME related all the disability back to applicant's 1999 injury for a different employer. Since all doctors unequivocally found no industrial cause, defendant had met its burden of rebutting the compensability presumption.

PROCEDURE

Agredano v. WCAB (2007) (non-published Court of Appeal opinion) 35 CWCR 112, 72 CCC 381

The applicant suffered an admitted industrial orthopedic injury in 1997 and received an Award of permanent disability and future medical treatment.

She timely filed a Petition to Reopen for New and Further Disability claiming to be suffering from depression resulting from the injury. Temporary disability payments were resumed and continued through April of 2005.

The applicant underwent several surgeries in May of 2002. Her treating doctor recommended additional surgery. He later reported however that the applicant was not a surgical candidate due to anxiety and psychological problems.

By late 2004 the applicant's psychiatrist had not cleared her for further surgery and in November of 2004 the treater found the hand condition permanent and stationary unless the applicant recovered psychiatrically enough for surgery in the near future.

In July of 2006, the applicant requested an Expedited hearing and the Judge held that the applicant was not entitled to temporary disability after April of 2005 and that her hand condition became permanent and stationary in November of 2004.

This was Appealed and the decision was affirmed by the WCAB.

The Court of Appeal affirmed the decision observing that the applicant did not expressly request the issue of psychological injury to be set for hearing. She only requested an Expedited hearing on the issues of medical treatment and temporary disability, not to determine whether she had an industrial psychological injury. The Court emphasized that only continuing temporary disability and treatment for the hand injuries were the issues to be litigated. The Court went on to note that an evidentiary hearing on the psychological injury claim may have violated defendants due process rights, absent notice that the issue was to be heard.

Linam v. WCAB (2007) 35 CWCR 86, 72 CCC 332 (certified for non-publication)

The applicant sustained a serious industrial injury when a scaffold collapsed. Eventually the case went to Trial on the issue of permanent disability. At Trial the evidence included testimony by a vocational rehabilitation consultant who stated that the applicant was unemployable and his injury caused 80-90% of his inability to work. The remainder was due to his pre-existing health, vision and illiteracy.

The applicant was awarded 81% permanent disability based on the medical opinion of Dr. Gherini, but was eventually vacated because it overlooked parts of the body. An ultimate award of 88% issued.

Both parties sought reconsideration and the applicant contended he should have been awarded 100% permanent disability based on the testimony of the consultant that he was unemployable.

The WCAB affirmed the permanent disability Award finding it in accordance with substantial evidence and that the vocational rehabilitation related testimony did not necessarily mandate an Award of total permanent disability.

The applicant sought review and the Fifth District, in one of its memorandums denying review, affirmed the decision of the Judge. The applicant apparently conceded in their Petition that the calculation of the 88% permanent disability was based upon substantial medical evidence. Since the applicant agreed that substantial evidence supported the WCAB finding that he is 88% disabled, the applicant failed to articulate any grounds to overturn the WCAB.

Mohamed v. Exxon-Mobil Corp. (2007) 35 CWCR 59

In a disputed case the applicant was represented by counsel who had him evaluated by Dr. DeBarry who found an injury and industrial hearing loss.

The defendants had the applicant evaluated by Dr. Patel.

A Mandatory Settlement Conference was scheduled and prior to the conference day the applicant's attorney requested a continuance to enable him to attend his son's graduation ceremony. The continuance was denied and the attorney arranged for a hearing representative to appear for the applicant. The representative did not submit a list of exhibits and witnesses.

At the hearing the WCJ admitted, over defendants objection, the reports of Dr. DeBarry and allowed the applicant to testify.

The Judge ultimately found that the applicant had sustained injury as alleged and awarded permanent disability.

Defendant's Petition for Reconsideration contending that applicant's testimony and Dr. DeBarry's reports should not have been relied on because the evidence was not disclosed at the Mandatory Settlement Conference.

In the Report and Recommendation the WCJ said that the testimony and the reports were properly received in evidence pursuant to the WCJ's duty to develop a record. The duty arises only when there is no substantial evidence and Dr. Patel's report was not substantial. The Judge further indicated that although

applicant was not listed as a witness the applicant may be implicitly assumed to be a witness on his or her own behalf.

The WCAB concurred pointing out that Dr. DeBarry's reports had been served on the defendants and in fact had been commented on by Dr. Patel. There was no showing of any prejudice or surprise by the admission of Dr. DeBarry's reports. Failure to list the evidence appeared to have resulted from a mistake rather than a deliberate decision to attempt to sandbag the defendant.

The WCAB went so far as to conclude that the defendants efforts appeared to be an exercise in gamesmanship and admonished the defendants that this could lead to the imposition of sanctions.

Nestle Ice Cream Company v. WCAB (Ryerson) (2007) 146 CA4th 1104, 35 CWCR 3, 72 CCC 13

The applicant sustained a cumulative injury which was eventually tried and an Award issued finding permanent disability, temporary disability and VRMA. However, the Award was erroneously made in favor of a different name and against a different defendant. The original Award was served on April 3, 2006.

On April 10, 2006 the applicant's attorney wrote the judge asking that the names of the parties be corrected and that the temporary disability and VRMA rates be amended from \$748.00 to \$840.00 per week.

The Award was amended accordingly and the amended decision was served on April 14, 2006.

The defendant filed a Petition for Reconsideration on May 4, 2006, 20 days after the Amended Award was filed and served but 31 days from the original decision.

The applicant responded indicating that the Petition was late and the WCAB dismissed the Petition as untimely, also it remanded the case for correction of a temporary disability period and placed a \$10,000.00 cap on the penalty.

This was appealed in the First District. In a published opinion, the Court of Appeal noted a series of Writ Denied cases where the WCAB had held that the time runs from the original award date when the amendments are merely "clerical." On the other hand when the amendment corrects a judicial error, a new 20 day period is triggered.

The Court of Appeal concluded that the amendments to the original decision were in fact substantial citing a case indicating that correcting the names to parties is a substantial change to a decision. Moreover, they noted that payment of benefits at a higher rate amounted to a substantial and material change in the award. It did not matter that the defendant was not currently challenging the aspects of the award that were changed by the amendment, the issue is whether the amendment was important enough to supercede the original award.

The Court annulled the Board's decision and remanded the case for reconsideration of the petition on its merits.

Philips v. WCAB (2007) (certified for non-publication) 35 CWCR 117, 72 CCC 406

The applicant sustained an admitted industrial injury and was sent a Compromise and Release which he signed. The document indicated that his earnings were \$420 per week and that he had been paid temporary disability at a rate of \$280 per week.

The Compromise and Release was approved in 2003 and about a year and a half later the applicant filed a Petition to Reopen to set aside this settlement on the grounds that the earnings information was correct. He was under the impression that adjustments to the temporary disability payments would be made, but they never were.

The unrepresented applicant testified that he had given evidence of earnings to a prior claims adjuster and ultimately to the current claims adjuster. That adjuster testified that he had never received such a fax and denied that he had ever told the applicant that they could negotiate earnings later after approval of the settlement.

The applicant did speak with the Information and Assistance Officer who said the Compromise and Release was adequate. The Information and Assistance Officer also had documents showing that applicant was to be a sports referee, but this was for events that had not yet occurred and this was not evidence of earnings.

Additionally the Information and Assistance Officer testified that she had an off the record discussion with the workers' compensation Judge regarding her intended testimony. The WCJ did disclose this information to the parties who agreed to waive the irregularity. The applicant was given time to submit tax documentation that he had allegedly faxed to the defendant but all he submitted was a phone record.

The Judge found that the record did not look like carrier fraud and that the Compromise and Release remained in effect. He found no earnings dispute had been established nor was there any misrepresentation.

Applicant filed a Petition for Reconsideration which was denied.

The in pro per applicant filed a Appeal with the Court of Appeal which found that good cause to reopen under Labor Code Section 5803 did not necessarily require fraud when it was filed within five years from the date of injury. You can only reopen after the five years from the date of injury with a showing of extrinsic fraud.

The Court held that the records showed good cause to reopen. It was conceded that there was no evidence of fraudulent misrepresentation but that there was evidence of excusable mistake that may have occurred.

The applicant may have provided the carrier with higher earnings documentation by the time the Compromise and Release was signed. Moreover, the Information and Assistance Officer informed the adjuster about the potential work as a referee which might be relevant. The adjuster's notes were ambiguous as to whether the applicant was told that the higher benefit rate could be shown after the Compromise and Release. Although the Compromise and Release was explained to him, because he was unrepresented he may have been mistaken about the terms.

The Court went on to discuss the exparte communication between the WCJ and the Information and Assistance Officer which the parties had agreed to waive. But since the applicant was pro per, that constituted good cause to overturn the decision as well. Moreover the Court found that the Information and Assistance Officer's notes were not in the WCAB file, and this was important because the notes could have alerted the WCJ about the dispute about the earnings.

Finally they found that a Petition for Reconsideration on the original Compromise and Release was not necessary in that the evidence showed the applicant mistakenly believed that challenging this settlement was not necessary because earnings could be further documented. They did however note that good cause to reopen is separate from a determination of whether or not the settlement should be set aside and they remanded the matter back to the WCAB for further proceedings.

Ramallah, Inc. v. WCAB (McKinley) (2007) 35 CWCR 181, 72 CCC 772 (certified for non-publication)

The applicant filed claims alleging injury AOE/COE that went to Trial with the Judge finding injury in two of the cases and awarding 77% permanent disability allocating liability in part to one defendant but the majority of the liability to CIGA.

Within the time frame the defendant filed a Petition for Reconsideration which was denied by the WCAB. However, the WCAB granted one filed by CIGA correcting a clerical error in the allocation.

Subsequently the defendant filed a second Petition for Reconsideration once again at the Fresno office, despite WCAB Rule 10840 expressly stating that all Petitions for Reconsideration of a decision issued by the Appeals Board in San Francisco must be filed there. The Petition alleged fraud based on some newly discovered sub rosa evidence. Eventually the Petition was received in the San Francisco office on November 28. CIGA also filed a Petition that was received on November 30.

Both Petitions were denied by the WCAB holding that they were untimely. The defendant filed yet another Petition which was dismissed as well by the Board as it was an impermissible successive Petition.

The Court of Appeal affirmed, observing that the jurisdictional period for reconsideration of the original August decision expired in September and the second Petition filed at Fresno on November 20 was therefore untimely. Since the second Petition was not properly filed there was no grounds for the filing of

the third Petition and hence there was no reviewable Order. The Petition for Review was denied and costs were awarded to the applicant.

Sarabi v. WCAB (2007) 151 CA 4th 920, 35 CWCR 150, 72 CCC 778

On 5/31/07, the 1st District Court of Appeal, division Two, agreed with the trial judge that since applicant had timely filed a Petition to Reopen and suffered a new and further disability within five years of the date of injury, the Board had jurisdiction to award temporary disability more than five years after that injury date.

Applicant suffered a right shoulder injury in August 1999. In December 2000 he received an award for temporary disability from the date of injury through early December 1999 as well as further care. He had surgery on the shoulder in January 2002 and filed a Petition to Reopen his case November 2002. In May 2004 the treater reported he was temporarily disabled and needed more surgery and in August 2004 an Agreed Medical Examiner agreed that applicant needed more surgery and could not be declared permanent and stationary at that time. Surgery was delayed because of the need to treat a nonindustrial condition.

The Agreed Medical Examiner issued a supplemental report in October 2005 stating that if applicant could not be cleared for surgery he would be deemed permanent and stationary as of August 2005, one year from the date of his evaluation. On receipt of that report, defendant stopped further benefits and claimed a temporary disability overpayment after mid-August 2005.

The trial judge awarded applicant continuing temporary disability from mid-August 2005, holding that there was jurisdiction to award such temporary disability even if the temporary disability arose more than five years of the date of injury because the Petition to Reopen had been filed timely. Further, the judge found that since treatment of the nonindustrial condition was needed before applicant could undergo the industrial shoulder surgery, defendant had to treat the nonindustrial condition to the extent it interfered with the industrial treatment.

A 2-1 panel decision reversed the judge, finding that there was no jurisdiction to award temporary disability which began more than five years from the date of injury.

The Court of Appeal noted that applicant filed a timely Petition to Reopen within five years of the date of injury. To recover temporary disability, the applicant must not only file a Petition to Reopen within five years but also show that new and further disability was suffered within that time frame or otherwise show “good cause” to reopen the prior award. The court indicated that the AME’s report of mid-August 2004 supported temporary disability and the need for further surgery, as well as medical from the treater who had been recommending surgery as early as May 2004.

It was all right in this instance to award temporary disability beginning in mid-August 2005 because there was no need to award benefits before that date since the defendant had been voluntarily providing them.

The AME report indicated that an award would have been justified for additional benefit within the five-year time frame. The court cited the liberal construction rule and annulled the panel decision, remanding the case for further disposition at the Board level.

Scott Pontiac GMC v. WCAB (Olsen) (2007) 35 CWCR 84, 72 CCC 346 (certified for non-publication)

The applicant alleged a 132(a) violation which was originally decided in defendants favor by a Judge at the San Francisco office of the WCAB.

The applicant filed a Petition for Reconsideration which was granted with the panel finding unlawful discrimination.

On the 25th day after the WCAB decision the defendants Petition was hand delivered by a messenger service to the local DWC office on the second floor of the San Francisco state building rather than to the Reconsideration office on the ninth floor.

By the time it was received by the Board, seven days later, the time for reconsideration had expired and the Board dismissed the Petition as untimely.

The defendant sought review contending that given the way the WCAB and the local San Francisco office were set up locating the correct place to file its petition was difficult. Thus they indicated there was excusable neglect under CCP 473(b).

The Court of Appeal did annul the Board's Dismissal Order but not based on CCP 473(b). They indicated that the WCAB should have deemed the Petition timely filed pursuant to Labor Code Section 5911. Petition should be decided on their merits rather than dismissing them based on procedural irregularities. "Simply because

it had to be transferred from one floor to another in order to be in the right department should not result in a dismissal".

Shannon v. CIGA (2007) 35 CWCR 260

Applicant claimed an injury to his back and psyche in mid-April 1997. The carrier then was HIH America. The trial judge issued findings and award in mid-June 1998 finding continuing temporary disability from 4/19/97 on, as well as for any injury as alleged. In May 2001 carrier was liquidated and CIGA assumed administration of its claims.

In 2004, CIGA filed a petition to terminate temporary disability which was ordered terminated after a hearing in August 2004. Further medical treatment was awarded at that time.

In early June 2005, applicant requested an expedited hearing on the need for surgery and additional temporary disability. Defendant agreed to provide the surgery at that hearing to contest the right to temporary disability. Further issues arose as to additional surgery and after trial, the judge found applicant in need of surgery and awarded continuing temporary disability. Defendant argued that the surgery was not justified by the evidence and that the judge lacked jurisdiction to award temporary disability more than five years of the date injury.

A Board panel supported the need for surgery but did not agree that the judge had jurisdiction to award further temporary disability.

The panel pointed to Labor Code sections 5410 and 5803. The first allows for collection of benefits for new and further disability within five years of the date of injury and the latter deals with good cause to re-open based on a petition filed within five years from date of injury. Once a petition is filed, the Board has jurisdiction to decide issues raised by said petition after five years from the date of injury. However, the worker had to have been suffering new and further disability within five years of the date of injury. A worker cannot confer continuing jurisdiction of the Board by prematurely filing a petition anticipating new and further disability which has not yet occurred, with the panel citing *Nickelsberg v. WCAB* (1991) 54 C3d 288, 19 CWCR 251, 56 CCC 476 and *Hartsuiker v. WCAB* (1993) 12 CA4th 209, 21 CWCR 1, 58 CCC 19. The Board still does have jurisdiction to determine permanent disability for that issue was not before it. As regards additional temporary disability starting up more than five years of the date of injury, the Board cannot award that. Jurisdiction was lost to award further temporary disability when the judge ordered a temporary disability terminated in 2004. Unless applicant was continuously temporarily disabled or a petition to reopen had been filed within five years, the Board has no jurisdiction to award further temporary disability. The panel negated the award of additional temporary disability, while allowing the surgery applicant requested.

Wal-Mart Stores Inc. v. WCAB (Collier) (2007) 35 CWCR 52, 72 CCC 210 (Certified for non-publication)

The applicant sustained an admitted injury in January 2000. In April of 2004 the parties Stipulated to an Award of 100% permanent disability plus further medical treatment.

Four months later the defendant requested a re-evaluation of the applicant's employability from one of the two vocational counselors. The counselor reiterated that voice activated software could be useful enabling the applicant to do some kind of work. It also obtains a copy of a job analysis with a notation by a QME who checked the box indicating that the applicant could do the job.

Based on that evidence the defendant Petitioned to reduce the permanent disability Award.

At Trial the Judge denied the request to reopen indicating that the defendant had offered no evidence that the applicant's condition had improved, and that the claim was simply an attempt to re-litigate the prior Award.

The Judge also denied a Utilization Review denial of occupational therapy.

A panel of commissioners denied Reconsideration adopting the Judge's Decision.

The Court of Appeal confirmed that there was no good cause to reopen and that it was merely an attempt to re-litigate the prior Stipulated Award.

The Court pointed out that there is no right to reopen on discovery of new evidence. This just an attempt to re-litigate the original Award. The new evidence must render the initial Award inadequate and must be more than cumulative and could not have been produced previously with reasonable diligence.

There was no explanation in this case why the evidence was unavailable prior to the Stipulated Award (emphasizing the fact that the Petition was filed four months after the Award) the counselor herself had already indicated in earlier reports the possibility of using such software. Moreover, they found the medical check the box type of report less than substantial evidence and there was no indication that her ailments had changed, particularly since the AME did not re-evaluate her.

With respect to the denial of Utilization Review, the defendants had contended that the applicant was to blame for not obtaining an AME to settle the treatment in dispute. However, the Court indicated that since the applicant had already received a Stipulated Award for further medical care the burden of demonstrating the care recommended by the treating physician was inappropriate would rest on the employer. Accordingly it was up to the employer to seek an agreed medical evaluation. Since that was not done the defendant's Appeal was rejected.

PSYCHE

Puga v. WCAB (2007) 35 CWCR 54, 72 CCC 195 (non-published)

In yet another “sudden and extraordinary” case the Court denied review but found that the fall from a ladder was not a sudden and extraordinary employment condition.

The applicant had worked for only two months and during the second month she had to install and repair ceiling fans. This required her to climb up and down ladders several times a day. She fell seven feet from a ladder sustaining injury to her neck and mid back and was awarded 2% permanent disability. The Judge indicated that the rest of applicant’s problems were psychological and thus were barred by Labor Code Section 3208.3(d) since she had only worked for two months.

This was appealed and the applicant argued that the fall was a sudden and extraordinary condition of employment constituting an exception to the six month threshold , thus allowing recovery for the psychiatric part of the claim.

Reconsideration was denied by the WCAB in a 2-1 decision.

This was appealed and in the memorandum The Court held that the sudden and extraordinary condition is limited to occurrences such as gas main explosions and violence in the work place that would normally be expected to cause psychic disturbance even in a diligent and honest employee.

The Courts quoted from the Wal-Mart Stores Inc. WCAB case and distinguished the Matea case. They emphasized that the applicant’s own testimony was that she was required to carry the ladder and used it several times a day, thus it was not extraordinary but integral to her duties.

SERIOUS & WILLFUL

Elk Grove Unified School District v. WCAB (Stroth) (2007) (certified for non-publication) 35 CWCR 114, 72 CCC 399

The applicant was a school teacher who sustained an injury when she was assaulted by an unruly student on bus. The injury was accepted and a Petition for Serious and Willful Misconduct was filed.

The evidence reflected that the student involved had a history of unprovoked physical aggression against other students and was making threats. Numerous complaints had been filed. The school district had made attempts to put him in a remedial program but his parents had refused to allow it. A school psychologist had decided that the student should be placed in a special educational program for emotionally disturbed students, but there was a 50 day waiting period involved. The student's mother insisted that he attend regular class until it was over. It was during this period that the student was injured.

The Judge found Serious and Willful Misconduct since the District knew about this student's potential danger and failed to take adequate measures to protect the applicant from him.

The decision was upheld by the WCAB and appealed to the Court of Appeals.

The Court of Appeal indicated that the District knew the danger and that it was aware that the probable consequences its continuance would cause injury to an employee. However they found that there was a failure to show that the District deliberately failed to act for the applicant's safety. They had pointed to the many occasions where they attempted to remedy the problem, the Court emphasized that the standard is one of Serious and Willful Misconduct not a standard of negligence. It is clear that the School District did make some effort to attempt to remedy the situation.

TEMPORARY DISABILITY

County of San Joaquin v. WCAB (Davis)(2007) 147 Cal. App. 4th 1459, 35 CWCR 45, 72 CCC 187

In a published opinion regarding earning capacity, the Court of Appeal affirmed the Trial Judge's Decision that an attorney injured on his first day of Jury Duty was entitled to have his benefits for temporary and permanent disability calculated at maximum rather than just the \$5 per day given to him as a county juror.

The Court applied Labor Code Section 4453(c)(4) to determine the "earning capacity". This particular sub section indicates that "where for any reason the first three methods cannot be reasonably and fairly applied, at average weekly earning capacity shall be used, consideration being given to all earnings from all sources".

Quoting *Montana & Goytia*, the Court had little trouble in awarding benefits at the higher rate.

Cruz v. Auto Dealers Comp. of Calif. (2007) 35 CWCR 268, 72 CCC 1281(en banc)

The Board, in a unanimous en banc decision, found that an amputation for Labor Code section 4656(c)(2)© purposes, must occur to some external projecting body part and not internal parts, even if bone is involved..

In this case, applicant suffered a back injury on 1/4/05 and had surgery about a year later consisting of an anterior L5-S1 discectomy, a partial L5-S1 vertebrectomy, an L5-S1 fusion with the graft from the left iliac crest bone, a bilateral L4-5 laminotomy and bilateral decompression of the L5 nerve roots.

TD was paid from early January 2005 through 1/17/07 and then terminated under Labor Code section 4656(c)(1). The trial judge found that applicant's surgeries constituted an amputation, since a portion of the hip and spine were removed. The judge also made a policy argument that since applicant obviously suffered serious consequences from an injury, the invasive procedures performed were sufficiently equivalent to the other enumerated special categories in the statute.

The Board pulled out ten of its dictionaries, all of which indicated that in "ordinary usage" amputation refers to removal of a limb or other external body appendage. With regard to the argument that applicant had suffered a serious or severe injury, Board indicated that there was nothing in the statute which used severity as a criterion for applying the exception to the 104 week limit. The Board also rejected the judge's reliance on section 3202. Such rule cannot supplant intent of the Legislature as expressed in a statute.

Commissioner Caplane concurred but felt that the section 4656 TD limitation was unreasonable and unjust.

Gunzenhauser v. WCAB (2007) (certified for non-publication) 35 CWCR 238, 72 CCC 1087

The Court of Appeal in the Fifth District found that the Labor Code Section 4656(c)(1) limitation of temporary disability to no more than 104 weeks within two years was in fact constitutional.

The facts were undisputed that applicant was injured and was still temporarily disabled after 104 weeks. The matter went to Trial and the Judge found that there was no further liability for benefits. The WCAB agreed.

However, the applicant argued to the Court of Appeal that the statute failed to comply with the constitutional mandate providing for the comfort, health safety and welfare for all workers. The limitation lessens it to below that standard and guarantees that workers will become public charges. The Court disagreed noting the additional benefits provided by permanent disability.

Hawkins v. State Compensation Ins. Fund (Amberwood Products) (2007) (en banc decision) 35 CWCR 183, 72 CCC 807

The applicant sustained an admitted cumulative injury to the neck in the course of her employment. The last day worked was July 16, 2004 and the carrier paid temporary disability for

the period July 17, 2004 through July 14, 2006. However the first payment of temporary disability was not made until May 3, 2005.

The matter proceeded to hearing and the parties stipulated that the applicant had not reached maximum medical improvement. Based on the facts of the case the Judge concluded that the two years from the date of commencement of temporary disability as provided in Labor Code Section 4656(c)(1) began on May 3, 2005, the date on which temporary disability was first paid.

Therefore the Judge awarded temporary disability from July 15, 2004 through the date of the Award and continuing thereafter.

Defendants appealed arguing that the date of commencement of temporary disability payments as described in 4656(c)(1) is the date for which temporary disability was started instead of the date in which benefits were actually paid.

The Board in an *en banc* decision affirmed the Judge's reasoning. To support its decision the Judge focused on the language in 4656(c)(1) indicating that "temporary disability shall not extend for more than 104 compensable weeks within the period of two years from the date of commencement of temporary disability payment." (emphasis added). Hence, they concluded that it was the intention of the legislature that the limitation of 104 weeks paid within two years begins on the date on which temporary disability was

first paid and not on the date that it is first owed. The majority argued that the statute was designed to encourage timely temporary disability payments.

In the dissent it has argued that the majority's opinion did not give full effect to the word "aggregate" in 4656(c)(1). Under the majority's opinion the term aggregate has no meaning because it would allow payment of more than 104 compensable weeks over a period of more than two years.

Norwood v. City of Los Angeles (2007) 35 CWCR 272, 72 CCC

Applicant was a maintenance laborer for the city. He suffered a severe injury on 3/17/05 to his neck and shoulders in an accepted case. He was provided "industrial injured-on-duty pay" for about a year and then temporary disability for another year. That point in the city stopped paying TD, arguing that 104 week limit had been reached since the first payment of TD per Labor Code section 4656(c) (1).

The trial judge found that these IOD payments were not temporary disability and awarded ongoing TD to the applicant because his medical condition justified it.

Apparently the Los Angeles Administrative Code defined IOD as replacing TD but the Labor Code is silent on that subject.

A Board panel considered the payment of IOD to be the payment of TD. The LA Administrative Code states that when an employee is certified off duty for temporary disability he shall receive an amount equal to his regular take-home pay in satisfaction of the city's obligation under Division Four the Labor Code. The intent to that section is that the worker will receive a higher rate of TD than other workers not similarly situated.

The panel felt that the IOD benefit year was the equivalent of the IDL paid to the applicant in *Salmon v. DOT* (2006) 34 CWCR 301 (en banc), which was also considered the equivalent of TD. Note that contrary to this holding is *Watson v. City of Oakland* (2006) 34 CWCR 331, in which payment of sacrosanct section 4850 time is not considered temporary disability for purposes of section 4656(c)(1)'s limit.

Van Ness v. Fireman's Fund Ins. Co. (7/25/07, MON 324743) Board panel decision

Applicant injured right middle toe on 10/20/04. The claim was accepted and applicant started receiving temporary disability. Gangrenous cellulitis developed, requiring amputation. While walking with crutches after the amputation, applicant developed right shoulder disability as a compensable consequence.

Defendant started paying TD on 10/22/04. In May 2006 Had shoulder surgery and continued on temporary disability. On 10/19/06, defendant terminated TD because of reaching the 104 week limit of section 4656(c)(1).

At trial, the judge ruled that the two injuries were interconnected and that the shoulder injury was the result of the amputation and applicant was entitled to extended TD per section 4656(c)(2).

Defendant filed a petition for reconsideration arguing that since the injured toe had healed and stabilized within two years, the judge should have used the 104 week limit.

A Board panel agreed with the trial judge. Although applicant had become permanent and stationary for his toe injury, the panel would not agree that his current temporary disability wasn't due to the toe condition but only to the shoulder condition and subject to the 104 week limit.

The plain language of section 4656 indicates that a worker who suffers an amputation is entitled to aggregate disability payments for any "single injury," for a limit of 240 weeks within five years from the date of injury. There is no statutory basis for giving a P&S date for the toe condition and a separate one for the shoulder. There is no statutory authority for apportioning TD. Since the amputation fell squarely within the plain language of (c)(2), there is no need to look for alternative interpretations.

132(a)

Anderson v. WCAB (2007) 149 Cal. App. 4th 1369, 35 CWCR 109, 72 CCC 389

The Second District found a violation of Labor Code Section 132(a) where the employee was required to use vacation time rather than sick leave to attend industrially related medical treatment when non-industrial workers were allowed to use their sick leave for medical appointments. The Court of Appeal also commented in Escobedo type apportionment.

The Court of Appeal distinguished the *Lauher* case by pointing out that in that case there was no evidence of disparate treatment whereas in this case there was a written policy requiring only industrially injured workers to use earned vacation time for attending medical appointments when non-industrially injured workers could use sick leave for such appointments. They found that the employer did not establish a valid business purpose for this policy.

Additionally, the Court upheld the determination that 4663 apportionment to “activities of daily living.” The Court found his explanation was appropriate and was based on reasonable medical probability. To be valid the nature of the disease should be discussed and why it is responsible for the approximate percentage of permanent disability. The AME conceded that his apportionment percentages were somewhat imprecise, but that does not mean that his conclusions were speculative. He indicated the factual basis for same as well as the fact that they were based on his medical expertise.