

Workers' Compensation Case Law Update

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written by:

James P. Pettibone

Barry M. Lesch

Laughlin, Falbo, Levy & Moresi

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INDEX

AOE/COE

<u>Tomlin v. WCAB</u> (2008) 162 CA4th 1423, 36 CWCR 103, 73 CCC 593	p.5
<u>Verga v. WCAB</u> (2008) 159 CA4th 174, 36 CWCR 4, 73 CCC 63	p.6

APPORTIONMENT

<u>Malcolm v. CNA Ins. Group</u> (2008) 36 CWCR 176, Order Denying Reconsideration	p.8
<u>Mills v. WCAB</u> (2008) 36 CWCR 138, 73 CCC 812 [nonpub.]	p.9
<u>Gorman v. WCAB</u> (2008) 36 CWCR 116, Order Denying Reconsideration	p.10
<u>Milivojevich v. United Airlines Inc.</u> (2007) 35 CWCR 317, Decision After Reconsideration	p.11
<u>Benson v. Permanente Medical Group</u> (2007) 36 CWCR 12, 72 CCC 1620 (en banc)	p.11
<u>Minvielle v. County of Contra Costa</u> (2008) 36 CWCR 199, 73 CCC ____	p.12
<u>Sherron v. American Cas. Co. of Reading, Pa.</u> (2008) 36 CWCR 201, 73 CCC ____, Order Denying Reconsideration.	p.13
<u>E & J Gallo Winery v. WCAB (Rubio)</u> (2008) 36 CWCR 197, 73 CCC1206 (nonpub.)	p.14

CHIRO CAP

<u>Facundo-Guerrero v. WCAB</u> (2008) 163 CA4th 640, 36 CWCR 131, 73 CCC 785	p.15
---	------

DISCRIMINATION

<u>LA County Professional Peace Officers' Assn. v. County of Los Angeles</u> (2008)165 CA4th 63, 36 CWCR 172, 73 CCC 1235	p.16
<u>Seabright Ins. Co. v. WCAB (Fitzpatrick)</u> (2008) 36 CWCR 32, 73 CCC 36 (nonpub.)	p.16
<u>Vaira v. WCAB</u> (2007) 35 CWCR 307, 72 CCC 1586 (nonpub.)	p.18

EMPLOYMENT

<u>Antelope Valley Press v. Poizner (SCIF)</u> (2008) 162 CA4th 839, 36 CWCR 83, 73 CCC 336	p.20
--	------

FEES

<u>Barr v. WCAB and DIR v. WCAB (Dorigo)</u> (2008) 164 CA4th 173, 36 CWCR 134, 73 CCC 763	p.21
<u>Carter v. AIG Ins. Co.</u> (2008) 36 CWCR 140, Decision After Reconsideration	p.21
<u>Costa v. SCIF/Hardy Diagnostics</u> (2007) 35 CWCR 12, 313, 71 CCC 1797, 72 CCC 1492 (en banc)	p.22
<u>Lopez v. SCIF</u> (2007) 36 CWCR 67, Order Denying Reconsideration	p.22

JURISDICTION

<u>County of Los Angeles (Dept. of Parks and Rec.) v. WCAB (Calvillo)</u> (2008) 36 CWCR 169, 73 CCC 798 [nonpub.]	p.24
---	------

LIENS

<u>Gutierrez v. Cedars-Sinai Health System</u> (2008) 36 CWCR 61, Decision After Reconsideration	p.26
<u>Tapia v. Skill Master Staffing and Liberty Mutual Insurance Co.</u> (2008) (en banc)	p.26

MPN

<u>Palm Medical Group Inc. v. SCIF</u> (2008) 161 CA4th 206, 36 CWCR 55, 73 CCC 352	p.28
---	------

NEW RAATING SCHEDULE

<u>Boughner v. Zurich America</u> (2008) 36 CWCR 111, 73 CCC 854 (en banc)	p.29
--	------

OLD/NEW?

<u>Vera v. WCAB</u> (2007) 154 CA4th 996, 35 CWCR 233, 72 CCC 1115	p.30
<u>Genlyte Group LLC v. WCAB (Zavala)</u> (2008) 158 CA4th 705, 36 CWCR 1, 73 CCC 6	p.31
<u>Zenith Insurance Company v. WCAB (Cugini)</u> (2008) 159 CA4th 483, 36 CWCR 29, 73 CCC 81	p.31
<u>Virginia Surety v. WCAB (Wragg)</u> (2008) 36 CWCR 4, 73 CCC 75 [nonpub.]	p.32
<u>Tenet/Doctors Medical Center v. WCAB (Reddrick)</u> (2008) 36 CWCR 59, 73 CCC 329 [nonpub.]	p.32
<u>Newlands v. WCAB</u> (2008) 36 CWCR 165, 73 CCC 1010[nonpub.]	p.33
<u>Virgina Surety Co. v. WCAB (Echelard)</u> (2008) 36 CWCR 196, 73 CCC 1218 (nonpub.)	p.33

PENALTY

<u>Ramirez v. Drive Financial Services and One Beacon Insurance Company</u> (2008) (en banc)	p.34
---	------

PROCEDURE

<u>County of Orange v. WCAB (Lean)</u> (2008) 36 CWCR 35, 73 CCC 1. (nonpub.)	p.36
<u>Beal v. Royal and SunAlliance</u> (2008) 36 CWCR 87, Decision After Reconsideration	p.36
<u>Target Stores v. WCAB (Sollars)</u> (2008) 36 CWCR 8, 73 CCC 56 (nonpub.)	p.37
<u>SCIF v. WCAB (Sandhagen)</u> and <u>Sandhagen v. WCAB</u> (2008) 44 C4th 230, 36 CWCR 133, 159, 73 CCC 981	p.37

SECTION 4850

<u>Jimenez v. Kings County</u> (2008) 36 CWCR 117, Decision after Reconsideration	p.38
---	------

STATUTE OF LIMITATIONS

<u>Earthgrains Co. v. WCAB (Hansen)</u> (2008) 36 CWCR 168, 73 CCC 1000 (nonpub.)	p.39
<u>CIGA v. WCAB (Carls)</u> (2008) 163 CA4th 853, 36 CWCR 136, 73 CCC 771	p.40

TEMPORARY DISABILITY CAP

<u>Brooks v. WCAB</u> (2008) 161 CA4th 1522, 36 CWCR 79, 73 CCC 447	p.41
<u>Wiley v. WCAB</u> (2008) 36 CWCR 107, 73 CCC 604 [nonpub.]	p.41
<u>Dupard v. Amerisource/Bergen Corp.</u> (2007) 36 CWCR 18	p.42
<u>Mt. Diablo Unified School Dist. v. WCAB (Rollick)</u> (2008) 165 CA4th 1154, 36 CWCR 194, 73 CCC 1212	p.43
<u>Foster v. WCAB</u> (2008) 161 CA4th 1505, 36 CWCR 82, 73 CCC 66	p.44
<u>Hinchcliff v. Sutter Health Corp.</u> (2008) 36 CWCR 178, Decision after Reconsideration	p.44

AOE/COE

Tomlin v. WCAB (2008) 162 CA4th 1423, 36 CWCR 103, 73 CCC 593

A divided court of appeal panel found in favor of a Beverly Hills Police Department Special Weapons and Tactics (SWAT) team member, overturning a Board decision which found against the worker having sustained an industrial injury while jogging on vacation in Wyoming. The court felt that the facts of the case, including the special need to maintain fitness and pass annual tests for SWAT duty, showed applicant's belief of his need to engage in such activity as reasonable. Location of the injury was irrelevant.

As a member of the Beverly Hills SWAT unit, applicant had to pass annual physical agility tests, including a half mile run climb a wall and drag a 150 pound object. Officers are paid to train four days a month and usually keep physically fit outside of work by running, biking and weight lifting. Applicant would usually run 3 or 4 times a week.

In 11/05, the SWAT team members were told they would have their physical testing in 1/06. Applicant began to prepare for the fitness test including during a two week vacation after Christmas in Wyoming. He was not told to train during vacation and didn't tell his supervisors that he would. However he felt that he had to train in order to pass the test. On 12/30/05, he slipped and fell at the end of a 3 mile run and broke his left ankle. He had surgery and ultimately came back to full duty.

The trial judge analyzed the case for the two-prong test of compensability of recreational activities set forth in Ezzy v. WCAB (1983) 146 CA3d 250, 11 CWCR 193, 48 CCC 611. The judge felt that applicant subjectively believed that his running was necessary to pass the SWAT test but that this belief was not objectively reasonable, failing the second part of the Ezzy test. The judge felt that finding this injury compensable would mean that every SWAT officer in California is covered for comp 24 hours per day anywhere in the world. A board panel denied reconsideration.

The court of appeal majority relied on Wilson v. WCAB (1987) 196 CA3d 902, 15 CWCR 201, 235, 52 CCC 369, which found a compensable injury for a volunteer Modesto SWAT member engaging in off-duty activity because fitness training was a reasonable expectancy of the assignment. The court distinguished the City of Stockton v. WCAB (Jenneiahn) (2006) 135 CA4th 1513, 34 CWCR 7, 71 CCC 5, which involved an off-duty basketball game with officers who were not members of any special unit.

The court did not care that applicant was running in Wyoming. Wherever he was training, it was done for the imminent, fitness test. The court was not phased by potential 24/7 coverage so long as the SWAT officer's injury followed an activity which was a reasonable expectancy of his job. The dissent expressed concern that an injury under these remote circumstances was totally outside the control of the employer, with no notice that applicant was going to engage in such activity and contrary to the legislative intent of § 3600(a)(9), which it is meant to limit liability rather than expand it. Viewing recreational activities as related to special fitness requirements imposes virtually limitless liability on the city.

Verga v. WCAB (2008) 159 CA4th 174, 36 CWCR 4, 73 CCC 63

The Court of Appeal, added further judicial depth and clarification to the meaning of the phrase "actual events of employment" as codified in Labor Code § 3208.3(b)(1).

The applicant was promoted to a new position in a new unit. Friction occurred between the applicant and her coworkers a result of her job performance and other issues. There was several memos written complaining about her aggressive attitude, rudeness etc.

The applicant testified that she was a victim with her coworkers taking "pot shots" at her. However the coworkers and supervisor testified that it was the applicant who was the problem and generated workplace difficulties.

Eventually the applicant obtained treatment and left work and filed a worker's compensation claim.

Applicant's medical legal evaluator found that her psychiatric disability was due to conflicts and negative interactions between her, her supervisor and coworkers.

The defense evaluator found that the applicant's problems were personal in nature or the result of good faith personnel actions.

This case proceeded to trial and the Judge found that the applicant's injury was non-compensable and that applicant's med legal report, which based its findings of compensability on the negative interactions, was not substantial evidence because those were not "actual events of employment". The Judge found that the applicant lacked credibility and that her perception was false. The Judge rejected the "honest perception" standard of Albertson's v. WCAB (Bradley) (1082) 131 CA3d 308, 10 CWCR 100, 47 CCC 460, which had been negated by the language in the new Labor Code § 3208.3(b)(1).

The applicant appealed and the Judge was upheld by the WCAB.

The applicant filed a writ which was accepted but the Court of Appeal then affirmed the WCAB.

The Court of Appeal in interpreting the phrase "actual events of employment" found it was meant to set a new and higher compensability threshold for psychiatric claims. Citing the **Hanna treatise**, the Court of Appeal found that the phrase "actual events of employment" requires "the employee to establish the objective evidence of harassment, persecution or other basis for the alleged psychiatric injury."

The WCAB specifically found no objective evidence that the supervisors or coworkers harassed the applicant. Hence, there were no actual employment events involved.

The applicant further argued that even if that was true she was still subject to the disdain of her coworkers and that it did not matter that her own conduct instigated the disdain. The court specifically held however that there was no evidence that the disdain caused the injury. The applicant's med legal report focused on the applicant's version of the alleged abuse which the WCAB found did not occur. Therefore it cannot stand as substantial evidence.

APPORTIONMENT

Malcolm v. CNA Ins. Group (2008) 36 CWCR 176, Order Denying Reconsideration

In a 2-1 Board panel decision, the majority affirmed a 25% apportionment of applicant's shoulder and hip PD to pre-existing osteonecrosis despite evidence that the disease process had been removed from the hip by a surgical joint replacement. A majority considered the cause of the hip disability to be the surgery and concluded the surgery was partially caused by the pre-existing osteonecrosis. The majority also felt that the agreed medical examiner had supported the shoulder apportionment in terms of medical probability with appropriate explanation of his opinion.

Applicant had two injuries in her employment. She had a specific injury to the left shoulder in 5/03 and one to the right hip in 10/04. Applicant had a total hip replacement in 7/05. In the 1990s she had undergone left knee surgery with osteonecrosis diagnosed when the surgery was performed.

The agreed medical examiner rated applicant and then considered the issue of apportionment. Although applicant denied having any physical difficulties before the injuries, the underlying osteonecrosis played a role. The doctor apportioned 75% of the disability to the injuries and 25% to nonindustrial causes.

In his deposition, the agreed medical examiner testified that applicant no longer had osteonecrosis because of the hip replacement but the disease process had contributed to the need for the surgery. Absent the osteonecrosis, she would not have fractured her hip in 10/04 and would not have required the hip replacement.

The trial judge went along with the apportionment the agreed medical examiner had stated, finding 15% permanent disability to the hip after apportionment and 11% permanent disability to the shoulder after apportionment.

The Board panel majority noted that since the enactment of SB 899, apportionment is based on causation of disability with the employer only liable for PD directly caused by the injury. The evaluator must determine the approximate percentage of PD which is a direct result of the injury and the approximate percentage of PD caused by other factors. The opinion cannot be speculative and must include reasons to support it. A majority concluded that the hip replacement was a direct result of the injury but the need for it was caused by other factors (osteonecrosis). This disease process was the cause of the disability even though no longer present in the hip. The majority refused to follow either City of Concord v. WCAB (Steinkamp) (2006) 71 CCC 1203 or Kien v. Episcopal Homes Found. (2006) 34 CWCR 228. These cases refused to find apportionment because the surgery had removed that degenerative process. The majority repeated its view

that the cause of the hip disability was hip replacement surgery and that the surgery was partially caused by the osteonecrosis and that was all that was necessary.

The dissenting commissioner indicated that since the osteonecrosis no longer existed, the disability was caused entirely by the surgery and that since medical treatment cannot be apportioned, the effects of medical treatment were what caused the permanent disability.

Mills v. WCAB (2008) 36 CWCR 138, 73 CCC 812 [nonpub.]

The Court of Appeal approved a Board apportioning the PD in an orthopedic case to an underlying preexisting nonindustrial respiratory problem. The orthopedic AME found that applicant was totally disabled but that 60% of the PD was due to his respiratory condition and the remaining PD related to his back condition. The AME's apportionment opinion was substantial evidence supporting the decision.

The worker had a history of lung problems, despite which he worked at his arduous occupation. He had a serious fall in 10/02 affecting multiple body parts. He was confined to a wheelchair since early 2003. The AME noted that two other doctors felt that applicant was totally disabled as a result of his lung condition and a third doctor that he was 75% disabled from that nonindustrial condition.

The judge at trial relied on the AME's opinion on apportionment. The applicant argued on reconsideration that no apportionment statutes allow for apportionment to a disability developing after the injury to a different body part and that it was not supported by substantial evidence.

The Board panel had no difficulty with the apportionment made by the AME. The panel also noted that if the injuries overlapped and there was some degree of subtraction of overlapping PD, applicant PD would have resulted in about a 10% award.

The Court of Appeal noted that it was dealing with a pre-existing nonindustrial end-stage obstructive pulmonary condition. The court noted that the worker argued that because he was able to work before his industrial injury he did not suffer from any prior disability and therefore "the combined level of PD he sustained from both the industrially admitted fall and his prior pulmonary condition should be entirely or largely attributable to his employment... We disagree. Elimination of such liability on the part of an employer for "lighting up" a non-disabling pre-existing disability, condition, or physical impairment is the very change intended by the Legislature in revising the apportionment statutes. Mills's attempt to apportion disability, rather than causation, in direct contradiction to §4663, subdivision (a), is unavailing."

The court also found the agreed medical examiner's opinion was supported by substantial evidence. The trial judge had expressly found his opinions thorough, comprehensive, well reasoned and persuasive and the opinion was not based on an incorrect legal theory or inadequate medical history. The court denied the petition.

Gorman v. WCAB (2008) 36 CWCR 116, Order Denying Reconsideration

A Board panel affirmed a trial judge's order denying a petition to reopen for new and further disability pursued by a correctional officer. He had previously been found totally disabled with 50% due to nonindustrial factors. Since he was already totally disabled, he could not have any additional industrial disability. He tried to argue the 2006 addition of Labor Code §4663(e), precluding apportionment in presumptive cases. That statutory amendment did not sanction amending a previously approved stipulated finding that applicant's permanent disability was total and that 50% of was due to other causes.

Applicant had a heart injury on 4/15/04 related to his correctional work. An AME in internal medicine indicated early in 2005 that applicant was totally disabled and further although there was no legal basis to apportion before SB 899, here he would have apportioned 50% of applicant's disability to nonindustrial factors including smoking and diabetes. This was the basis for a stipulated findings and award in 10/05.

Applicant later had a heart transplant and his body initially rejected followed by aggressive immunosuppressant treatment and a severe viral infection followed.

In 2007, he was reevaluated by the AME who reported that applicant remained totally disabled. Applicant filed a petition to reopen and the parties stipulated that Labor Code § 3212.2 was applicable. [Note there is no anti-attribution clause in § 3212.2] The trial judge found that applicant had not sustained new and further disability because he was already totally disabled and he could not sustain any additional PD. On reconsideration, applicant argued that § 4663(e) precluded apportionment and that was the basis for new and further disability.

A unanimous Board panel agreed there was no new and further disability because applicant knew before his heart transplant that he was totally disabled. Having gone beyond total disability to something potentially worse was not the same as new and further disability.

Further there was an unresolved question as to whether § 4663(e) is a change in the law which would have been good cause to reopen under sections 5803 and 5804. The issue was not raised and therefore the panel could not rule on it.

Milivojevich v. United Airlines Inc. (2007) 35 CWCR 317, Decision After Reconsideration

The applicant suffered a stroke arising out of his employment. In 2004, in an Award, the injury was found to have caused 91% permanent disability based on a cumulative trauma. There was no disability apportioned.

The applicant then filed a Petition to Reopen, claiming new and further disability. The former QME then evaluated as an AME who wrote on July 1, 2005 that he had not previously apportioned applicant's disability because the injury occurred before the effective date of SB 899. In light of the amended 4663 he would have attributed 40% of the stroke condition to the applicant's elevated cholesterol and 60% to occupational factors.

In a supplemental report, the doctor indicated that the high cholesterol was not a pathologic condition in and of itself leading to stroke or heart attacks. However, it does have long term consequences to an individual human although it may not be causing disability at the moment.

The doctor went on to indicate that apportionment of causation of disability to risk factors was not appropriate and distinguished between risk factors and an actual disease entity. These factors are predicated on a statistical analysis but one does not know who in the group who has risk factors will actually develop the problem. They are simply characteristics that increase the possibility of disease or injury, but they are not the disease or the injury itself.

The case went to trial and the judge once again followed the AME and found the applicant had increased to 100% but that 40% of the increase was caused by nonindustrial factors thus awarding a rating of 96%.

Both parties filed reconsideration petitions with the applicant filing on the issue of apportionment claiming that substantial evidence was not introduced.

After reciting the usual mantra about substantial evidence they indicated evaluators must explain how and why a portion of the disability is being caused by factors other than the injury.

The panel found the doctor did not attribute the apportionment part of the disability to any underlying pathology. Moreover he did not distinguish between cause of the injury and cause of the disability. He apportioned to a known risk factor for injury but not to a cause of permanent disability. Moreover, he failed to use the magic words of reasonable medical probability.

Accordingly the panel increased the disability to 100% with no apportionment.

Benson v. Permanente Medical Group (2007) 36 CWCR 12, 72 CCC 1620 (*en banc*)

The Board, with one dissenting Commissioner, overturned a trial judge's combining permanent disability for two injuries to the same body parts which became P&S at the same time, overruling the hoary precedent

of **Wilkinson v. WCAB** (1977) 19 C3d 491, 5 CWCR 87, 42 CCC 406, which, under old §4750, allowed for such injuries to be combined for rating purposes and created a great deal of subsequent mischief when its rationale was stretched beyond recognition to combine PD in a great many other rating situations.

In **Benson**, applicant suffered a specific spine injury on June 3, 2003 while working as a file clerk at Permanente. She had a three-level fusion in 2004. The AME evaluator wrote in 2005 that applicant actually had two separate injuries, the specific injury noted and a cumulative claim during her Permanente employment and culminating in disability on that date. The AME limited her to semisedentary work and found her P&S in late September 2005. The doctor divided liability equally between the two injuries he found. After applicant's attorney filed a cumulative claim based on the doctor's opinion, the case came on for trial and applicant was awarded a single 62% PD.

On appeal, defendant argued that there should be two separate ratings of 31% each. The majority of the board agreed, feeling that the **Wilkinson** doctrine had been overturned by new sections 4663 and 4664 and **Brodie v. WCAB** (2007) 40 CA4th 1313, 35 CWCR 143, 72 CCC 565, which indicated that old sections 4750 and 4663 were out the door because they did not reflect the new "causation regime" for rating and apportioning disabilities. Combining PD awards is inconsistent with causation-based apportionment as enunciated in **Brodie**, which asked whether the new method of apportionment required rejection of the formula from **Fuentes v. WCAB** (1976) 16 C3d 1, 4 CWCR 23, 41 CCC 42, and the answer was resoundingly in the negative. **Fuentes** is still good law. Since each of applicant's injuries was equally responsible for permanent disability, she was entitled to separate awards of 31% for each such claim.

A writ has been granted by the First District Court of Appeal in this case (A120462 on 6/26/08, with no time yet set for oral argument), and the Board's en banc decision is therefore vacated. We have not heard the last of whether the **Wilkinson** doctrine lives, despite **Brodie** and **Fuentes**. This case is not a particularly good one factually for the defense since we really do not have two successive injuries but actually two simultaneous injuries, the date of injury for the cumulative claim being the date disability manifested itself, which is also the date of the specific injury.

Minvielle v. County of Contra Costa (2008) 36 CWCR 199, 73 CCC ____

The Board panel rescinded a trial judge's apportionment between a May 1992 back injury award of 27-1/2% and a 2004 back injury rated at 31% under the new schedule which merely subtracted the PD under the old 1950 rating schedule directly from the PD under the new schedule and came up with a 4% rating.

Fortunately (perhaps), the evaluating doctor for the earlier injury was still practicing and served as the AME in the latter case. He opined and the parties thereafter stipulated that the older injury yielded a 27-1/2% award and that if the 2004 injury were rated under the old schedule, the overall rating would now be 55%. Likewise, if the AMA Guides were used to rate the older injury, permanent disability would have been 18%. The present overall disability under the new schedule is 31%. Add into the mix the fact that applicant claimed that he fully recovered from the effects of the earlier industrial injury.

The trial judge decided that section 4664 mandated simple subtraction of the prior rating from the current rating, "regardless of which rating system was used." The judge did not feel that the Legislature intended the prior award to be recalculated under the new schedule for apportionment purposes.

A Board panel concluded that the judge's analysis was in error. It is inappropriate to simply subtract one rating from the other because different standards were used to calculate PD caused by each injury. The Board pointed to the case of *Kopping v. WCAB* (2006) 142 CA4th 1099, 34 CWCR 251, 71 CCC 1229, to indicate that the defendant must prove the existence of the prior award and the overlapping nature of the disabilities between the two cases.

Since different rating systems were used, section 4664 does not apply. If section 4663 were used, there would be no apportionment because applicant had fully recovered from the effects of the 1992 injury.

The panel concluded that further proceedings were necessary to determine whether it was possible to rate the PD from the 1992 injury under the same standard as the 2004 injury to be able to utilize section 4664.

Sherron v. American Cas. Co. of Reading, Pa. (2008) 36 CWCR 201, 73 CCC___, Order Denying Reconsideration

Applicant injured his knee in June 2003 while working as a hod carrier, after starting with the employer two months earlier. Although his treater said he was permanent and stationary about a year after the injury, the PTP subsequently operated on the knee, making applicant temporarily disabled once again.

Applicant received a QME orthopedic evaluation calling for a 50% rating. However, the evaluator questioned applicant's ability to engage in retraining. A vocational expert hired by applicant's counsel then analyzed the case and found applicant unable to compete the open labor market. A defense expert disagreed.

Applicant had dueling psychiatric evaluations. The applicant's evaluator found him suffering from adjustment disorder related to the knee injury. The defense evaluator found that applicant had limitations in all eight psychiatric protocol categories but attributed them to a pre-existing learning disability. The latter report was rated at 26%.

After trial, the judge found that applicant had suffered an injury to the knee but had not suffered an industrial psychiatric injury. He was felt to be permanently totally disabled with 26% of the disability caused by pre-existing factors. The judge did not consider any of the psychiatric problem to be industrial because of applicant's short period of employment, which did not meet the requirement in Labor Code section 3208.3(d), that the injured employee work for the employer for six months before psychiatric injury can be claimed (with some limited exceptions).

The judge rejected the argument that the new schedule should apply because of the treating physician's 2004 report finding that applicant was stabilized with disability factors, rejecting defendant's effort to bring

this injury within the new schedule. The standard to apply here for his work capacity was his ability to compete in the open labor market. An applicant's inability to benefit from rehab was a factor to be considered in determining his disability. The evidence did show that he was prevented from successfully competing in the open labor market. However, 26% of that disability had to be subtracted as a nonindustrial source of his overall disability.

E & J Gallo Winery v. WCAB (Rubio) (2008) 36 CWCR 197, 73 CCC 1206 (nonpub.)

Applicant hurt his left shoulder on the job in 2004. The case was tried based on 2007 reports from an agreed medical examiner and a 2000 report from a different orthopedist, describing disability from a 1999 injury. The trial judge found 15% PD without apportionment and reconsideration was sought because the judge did not apportion 11% to a prior injury which applicant had failed to disclose. The Board adopted the judge's reasoning that there was no evidence that applicant had actually received an 11% award nor, assuming such an award existed, that there was evidence of overlap between the two injuries.

The Court of Appeal, in a memorandum opinion, found that the only evidence of this prior injury was reference in the orthopedic report of 2000. Defendant blamed the applicant for not producing a prior award but that burden is on the defendant. That is particularly true here because the 1999 injury occurred for the same defendant involved in the 2004 injury. Per the court, "if a prior PD award existed, defendant had only to search its own files (emphasis added) [Editor's note: No Comment.]" Applicant actually denied ever having received the prior award. Further, the current AME report failed to state the approximate percentage of PD caused by "other factors." Nothing in the QME report addressed overlap and the current disability related to loss of range of motion in the shoulder and a pain add-on under the current rating schedule

CHIRO CAP

Facundo-Guerrero v. WCAB (2008) 163 CA4th 640, 36 CWCR 131, 73 CCC 785

The First District Court of Appeal affirmed a Board decision limiting applicant to 24 chiropractic visits as specified in Labor Code § 4604.5(d). The chiropractor involved and his statewide organization, among others, mounted constitutional arguments, charging that the statute violated the California constitutional mandate that a complete system of workers' compensation must include "full" provision of medical treatment; giving the employer the discretionary authority to approve more than 24 visits without any right to challenge that authority is a denial of due process; and limiting people unfortunately injured after January 1, 2004 to 24 visits while those injured earlier had unlimited visits was a denial of equal protection.

The court applied the rational basis standard, noting that the Legislature created this statute in response to a perceived financial crisis at the time in the comp system, and that such provision is rationally related to alleviating that perceived and articulated problem. Thus, the statute is constitutional. This case is fully consistent with decisions like **Wal-Mart Stores v. WCAB (Garcia)** (2003) 112 CA4th 1435, 31 CWCR 289, 68 CCC 1575, which upheld the constitutionality of the six-month employment requirement for psychiatric claims and **Rio Linda School Dist., v. WCAB (Scheftner)** (2005) 131 CA4th 517, 33 CWCR 179, 70 CCC 999, which upheld the constitutionality of the new apportionment statutes under SB 899.

The worker's comp system is a creature of statute, not creating vested, fundamental rights in applicants. That being the case, the statute merely has to have a rational basis for it to be upheld. Our compensation crisis was such a basis.

DISCRIMINATION

LA County Professional Peace Officers' Assn. v. County of Los Angeles (2008) 165 CA4th 63, 36 CWCR 172, 73 CCC 1235.

LA County was found to violate Labor Code §§ 4850 and § 132a regarding its practice of refusing to allow industrially injured deputy sheriffs to count payments for excess accumulated vacation hours toward calculating their retirement benefits, while allowing other sheriffs their duties to do so, thus raising their retirement benefits.

The County's policy was to permit a deputy sheriff to accumulate unused vacation time, then defer that time (beyond 320 hours) to the following year, and then receive a "cash out" payment for it. If such cash was received in the deputy's final employment year, it was treated as "pensionable income" which enhanced a deputy's retirement. However for a deputy who retired in a year following a § 4850 leave for work-related injury, the County would not cash down those deferred excess hours but rather they stayed in the deputy's account and if he retired in the year following the § 4850 leave, he never got the opportunity to cash out or use the hours, but was only compensated for them at retirement and such payment is not considered "pensionable income" and added into the calculation of retirement benefits.

The court noted that § 4850 prohibits discrimination in "salary." The court noted that this section talked about paying a temporarily or permanently disabled public service officer compensation "without loss of salary" during the time of incapacity.

The court did not accept the County's arguments trying to justify this differential treatment. The County argued that it was provided the injured deputies everything that § 4850 required. The court observed this argument was irrelevant. The County complied with the law and the fact that it didn't discriminate against the injured deputies' compensation payments had nothing to do with the specific policies at issue been discriminatory and treating that the deputies differentially.

Seabright Ins. Co. v. WCAB (Fitzpatrick) (2008) 36 CWCR 32, 73 CCC 36 (nonpub.)

The applicant sustained an admitted industrial injury in December of 2001. Several body parts were injured and the applicant received a great deal of medical care. In addition to some fractures, an MRI and bone studies revealed the presence of osteopenia.

The applicant was eventually found by her treating physician in 2002 to be permanent and stationary with the semi-sedentary work restriction with 50% related to her injury and 50% related to her pre-existing condition.

However, the applicant continued to request additional treatment and there was some litigation over various treating physicians.

Eventually the applicant was evaluated on her behalf by Dr. Roback who found her permanent stationary as of August 27, 2004 with a limitation to between semi-sedentary and sedentary work. He found no apportionment.

The applicant was evaluated by the defendant's doctor, Dr. Renbaum, who precluded her from heavy work and apportioned 35% to the pre-existing conditions. Eventually Dr. Roback submitted a supplemental report indicating that it would be appropriate to apportion 10% of the applicant's permanent disability to pre-existing osteopenia.

The case eventually went to trial in 2006 and rating instructions were drafted based on Dr. Roback's report including the apportionment resulting in a 68% rating.

The applicant cross-examined the rater and presented rebuttal evidence in the form of the testimony of a vocational rehabilitation expert. The Judge eventually issued a decision on December 5, 2006 awarding permanent disability of 68% but also temporary disability from January 2000 to through November of 2005. Pursuant to defendant's request for clarification, the judge issued an amended award on December 26, 2006 correcting the end date of temporary disability from 2005 to 2002.

Eventually the applicant petitioned for reconsideration of the December 26 decision on January 19, 2007. The defendant responded that the petition was untimely except as to the temporary disability issue since the applicant did not seek reconsideration of the original decision and the amended award only changed the temporary disability finding.

The WCAB rejected the defendant's argument stating that the time limit ran from the date of the amended award and also rejected the applicant's arguments except to award an additional period of temporary disability from April 2003 until April 2004, as recommended by the judge in his report on recon. The judge specifically rejected the vocational rehabilitation expert's testimony and found no grounds to reject the apportionment. The Board deferred the calculation of PD after apportionment until the Supreme Court decided the issue.

This was appealed in the Court of Appeal but specifically found that the applicant's petition for reconsideration was timely as the reconsideration time limit runs from the date of the amended decision if it makes a substantive change in the original award, as opposed to a merely clerical one. Changing the TD ending dates 2005 to 2002 was a material change.

Eventually the court affirmed the temporary disability award but rejected the applicant argument that it was error to reject the testimony of the vocational rehabilitation expert, indicating that it was simply a

substantial evidence argument in disguise. The only salient point on PD raised by the applicant was rejected as well. It charged that a portion of the rating was based on an “underground regulation” outside the schedule. There was no citation to specific authority and it was brought up in a footnote. The Court indicated that arguments raised in footnotes without headings or subheadings are forfeited.

They did however agree with the applicant's arguments on apportionment indicating that Dr. Roback's report was not supported by Escobedo v. CNA Ins. (2005) 33 CWCR 100, 70 CCC 604 (en banc). The court did not address the applicant's other arguments that apportionment to the osteopenia violated the rule that the employer takes the injured worker as it finds her and that apportionment to age and gender related risk factors were discriminatory under state and federal law. However the court specifically indicated that this discrimination claim "fails at the threshold" because the applicant did not support her argument that osteopenia is age and gender related with any citations, authority or request for judicial notice.

Vaira v. WCAB (2007) 35 CWCR 307, 72 CCC 1586 (nonpub.)

The Court of Appeal, in a non-published decision, indicated that apportionment to age in and of itself may be impermissibly discriminatory under state law.

The applicant was 73 years old when she suffered a back injury while bending over to pick up some brochures. She had had one earlier industrial injury.

The AME found a compression fracture had become permanent and stationary and that applicant's age and underlying osteopenia (osteoporosis) contributed to the disability and apportioned 40% to those factors and 60% to the industrial injury.

The parties stipulated to the overall permanent disability and litigated the apportionment issue with the Judge initially apportioning 40% of the permanent disability to nonindustrial factors.

After a series of appeals, eventually the applicant sought review challenging apportionment to age and osteoporosis and the reduction of permanent disability based on a prior award.

The Court of Appeal affirmed that apportionment under the new §§4663 and 4664 is in fact different than before and you can now base apportionment on pathology and previously asymptomatic causes.

The court went on to agree that the AME's opinion in this case was a bit unclear as to whether or not he was apportioning to disability as opposed to the contribution of pre-existing problems to the injury. One must only apportion to disability.

The applicant further argued that any reduction of her award based on age and osteoporosis constituted age and gender discrimination citing Government Code § 11135(a).

The court said that the WCAB may not use risk factors of the injury in apportioning disability which is why they remanded the matter to clarify the AME's analysis.

In discussing the osteoporosis issue the Court held that that it was not discrimination but simply a recognition that part of the disability existed independent of the industrial injury. However, to the extent you base apportionment simply on age it would violate the Code. The WCAB may not reduce a disability award just because the applicant may be older than other similarly situated workers.

In the instant case they could not tell if that is what the AME did. They went on to indicate, however, that to the extent that a condition which might contribute to a work-related disability arises or becomes more acute with age, they we saw no problem with apportioning disability to that condition.

"In this case, when Dr. Johnson mentioned petitioner's age as a contributing factor of her disability, he may have been referring to the fact that her osteoporosis has become more acute with age. On the other hand, he may have been using the term age as a shorthand reference to many other physical and mental conditions that tend to come with age." They found that further evidence would be necessary.

EMPLOYMENT

Antelope Valley Press v. Poizner (SCIF) (2008) 162 CA4th 839, 36 CWCR 83, 73 CCC 336

The Second Appellate District affirmed a trial court's decision which upheld the Insurance Commissioner's finding that newspaper delivery carriers employed by Antelope Valley Press are employees rather than independent contractors for workers' compensation purposes.

The court went through an exhaustive analysis of the facts in this matter and felt that the factors set forth in the S.G. Borello and Sons v. State of California, DIR (1989) 48 C3d 341, 17 CWCR 61, 54 CCC 80, supported a finding that there was an employer/employee relationship. The fact that everybody had signed an independent contractor distribution agreement did not change the result.

The result in this case was also consistent with an earlier newspaper carrier case, Gonzalez v. WCAB (1996) 46 CA4th 1584, 24 CWCR 168, 61 CCC 566.

FEES

Barr v. WCAB and DIR v. WCAB (Dorigo) (2008) 164 CA4th 173, 36 CWCR 134, 73 CCC 763

The Court of Appeal ruled in these cases that preparation of the VR expert's report is reimbursable under Labor Code § 5811, regardless of whether the report itself is admissible in evidence. The test is not whether the report would be admissible but rather whether the costs were reasonable and necessary one incurred.

In Barr, the worker had injuries in 1999 which were settled by C&R in 2004. He then filed against the SIBTF in 2006 and used a VR expert to evaluate the case. The expert found applicant 100% disabled. The case was settled by stipulation but defendant refused to pay the consultant's bill because there was no trial and no testimony taken. The judge disallowed the bill because the case was settled before trial. In Dorigo, the same scenario occurred with a settlement, followed by a SIBTF claim and the same expert then prepared a report. The SIBTF case was settled before trial. This judge found that the costs were reasonable and necessary and awarded them.

In both instances, a Board panel approved the judges' findings. The Court of Appeal indicated that the Board had broad discretion to award costs per § 5811. The court also pointed to §§ 5708 and 5709 to indicate the Board's flexibility in making inquiry to determine the parties rights without being bound by rules of evidence or civil procedure.

The court pointed to Costa v. Hardy Diagnostic (2007) 35 CWCR 313, 72 CCC 1492 (en banc), to find that such costs were allowable under § 5811 even when excluded from evidence because based on incorrect assumptions, calculations and factors. The VR evidence doesn't necessarily have to affect the PD rating it must however at least have the potential to affect a PD rating to be recoverable. The court observed that adage it had been given no statutory or case law which would require the Board to preclude a costs award as a matter of law. The court did not feel that it should act legislatively to create such law, finding that the flexible language of § 5811 controls.

Carter v. AIG Ins. Co. (2008) 36 CWCR 140, Decision After Reconsideration.

Applicant suffered a specific injury in 2004 and a cumulative running into 5/05 during her employment. The claims were accepted. Applicant treated with a pain management specialist and the parties agree to an internist to evaluate. Defendant set the deposition of the physician which was taken in 6/07. Applicant's attorney asked for a fee for services at the deposition and he was awarded such fees in 8/07. Defendant objected on the judge rescinded the decision. In 3/08 after further proceedings, the judge ordered defendant to pay fees for preparation and attendance to be adjusted by the parties. Defendant filed for reconsideration. In his report on recon, the judge agreed that § 5710 did not provide for such fees to attend

an AME's deposition. However, the Board's Policy and Procedural Manual talks about fees being sufficient to encourage competent attorneys to participate in the comp practice. That policy is more compelling after 2004 legislation which has led to more physician depositions because of the new schedule and broader apportionment statutes. There were compelling reasons to award a fee under §5811, at least when the defendant sets the AME's deposition.

The Board panel rejected the rationale. Section 5811 permits allowance of costs but no authority to allow an attorney's fee as a cause. The judge's public policy arguments should be directed to the Legislature. The fee award was reversed.

Costa v. SCIF/Hardy Diagnostics (2007) 35 CWCR 12, 313, 71 CCC 1797, 72 CCC 1492 (en banc)

These en banc decisions establish the place of vocational rehab consultants as appropriate expert witnesses on the issue of the DFEC used in a particular case.

The case was concerned with how and when to pay these experts. The board indicated that the qualifications of each expert needed to be viewed on a case-by-case basis. The evidence they presented does not have to successfully alter the PD rating and must be able to potentially affect the rating, in order for charges to be reimbursed.

The court ruled that the cost of written rebuttals to PD rating are properly included within Labor Code §5811. The Board pointed to the authority of **LeBoeuf v. WCAB** (1983) 34 C3d 234, 11 CWCR 185, 233, 48 CCC 587, as evidence of the role of vocational testimony in determining PD. Since then, the Board has continued to allow reasonable expert witness fees under §5811 to present evidence on and/or in rebuttal to an old schedule PD rating and allowing the same under the new schedule is not inconsistent with SB 899. §4660(c) indicates now, just as it had in its prior manifestation, that the schedule "shall be prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by this schedule." Prima facie evidence must allow for introduction of evidence on or in rebuttal to the rating schedule.

Lopez v. SCIF (2007) 36 CWCR 67, Order Denying Reconsideration

This case follows **Costa** and affirms the Board's authority to order payment for the report of such vocational expert under Labor Code § 5811. In **Lopez**, defendant charged that the report was not reasonable because it was obtained before a recommended rating was served and that the expert was not qualified to give an opinion on DFEC, contentions which were rejected with reference back to **Costa**. In this case, the expert testified that his DFEC analysis was broken into two components: 1) determining the post-injury vocation

and wages of applicant and 2) a numeric formula developed by economists. It is not clear whether the expert's own numeric formula was directed at rebutting the range of ratios of ratings to proportional wage losses referred to in the current rating manual (generally pages 1-5 through 1-8). Further, in accord with the § 5811 "let them eat cake" rationale, are the cases of **Barr v. WCAB** and **DIR v. WCAB (Dorigo)** (2008) 164 CA4th 173, 36 CWCR 134, 73 CCC 763, advising that the Board is not encumbered by traditional rules of evidence and has considerable discretion to award such fees for such expert testimony.

JURISDICTION

County of Los Angeles (Dept. of Parks and Rec.) v. WCAB (Calvillo) (2008) 36 CWCR 169, 73 CCC 798 [nonpub.]

This is a significant case in the ongoing attempt to cut applicants off temporary disability more than five years from the date of an injury. The court sets up a black letter rule that hopefully will lead the Board and other courts to similar conclusions, though this case is unfortunately and inexplicably unpublished.

The facts are somewhat complicated. Applicant hurt several body parts late in September 1997. About a year later, the parties entered into a stipulation about applicant's temporary disability rate with the defendant agreeing to pay outstanding sums at that rate. Shortly thereafter, applicant had cervical surgery. In March 1999 the parties stipulated that applicant was to be paid at the rate previously stipulated to and defendant would pay any sums outstanding retroactively. In August 1999 the parties entered into a stipulation to settle a penalty issue. Applicant had knee surgery in 2000 and was declared permanent and stationary in 2002, with a limitation to semisedentary work. Applicant had gotten temporary disability up to that P&S report. She then received vocational rehabilitation indemnity into April 2003. Nothing further happened in the case until October 2005, when her treater reported applicant was temporarily disabled and now needed lumbar surgery on an industrial basis, and was going perform it the following day.

The parties tried the issue of TD from the date the doctor indicated applicant needed surgery with penalties for failure to pay the TD. The judge issued an award for the requested temporary disability at a slightly higher TD rate (likely the result of higher subsequent earnings) and found a penalty for failure to pay that TD. The judge ruled that there was no need for a petition for continuing jurisdiction because the Board had continuous jurisdiction as it never made an award in the case. Since applicant was not temporarily partially disabled, § 4656 did not forbid a TTD award. Defendant argued that the earlier stipulations were such an award, to no avail.

The Board panel agreed in essence with the trial judge and indicated that since there was no award of benefits within five years of the date of injury, there was no issue of continuing jurisdiction; it existed without argument.

The Second District Court of Appeal disagreed. It did not believe that the existence of a prior award or not was relevant. The 1978 amendment to section 4656 to limit the payment of temporary partial disability to 240 weeks within five years of the date of injury had no effect on the issue of limitation on the payment of temporary total disability. Such an expansive interpretation was rejected by the Supreme Court in **Nickelsberg v. WCAB** (1991) 54 C3d 288, 19 CWCR 251, 56 CCC 476 and by the Court of Appeal in **Hartsuiker v. WCAB** (1993) 12 CA4th 209, 21 CWCR 1, 58 CCC 19.

This Court indicated that **Nickelsberg** ruled that the 1978 amendment to section 4656 which one applies to injuries up to the date of reform legislation on 4/19/04, only allows extension of temporary total disability beyond five years from the date of injury when such period of TTD starts within the five years and then is

continuous and "spills over" to a time frame beyond the five years. This has nothing to do with the issues of continuing jurisdiction or not. It is based on the legislative history and the language of the statute. The Supreme Court's opinion is controlling in this case and the Board's award of a period of temporary total disability beginning more than five years from the date of injury was reversed.

LIENS

Gutierrez v. Cedars-Sinai Health System (2008) 36 CWCR 61, Decision After Reconsideration

In October 2003, the applicant filed a claim alleging injury occurring back in 2000. The defendants denied liability for the injury claiming that although she did have an accident at work that was reported there was never any claim of injury or need for medical treatment. Moreover they cited the fact that she filed the claim after she had been terminated.

The lien claimant filed liens totaling over \$8,000. The applicant and defendants settled the case, other than the lien claims, by Compromise and Release, which included a Thomas finding.

Eventually the matter proceeded to trial on the lien claim. The lien claimant appeared but did not present any evidence on injury. Some medical reports were entered into evidence, as was a statement from a bill review company indicating that the reasonable value of the services were \$3,696.

The judge found that the applicant sustained an injury as alleged and awarded lien claimant the \$3,696.

The defendants filed a petition for reconsideration which the WCJ recommended be denied.

In a split decision the Board granted reconsideration concluding that the judge's finding of injury was not justified by the evidence. An employer has no workers' compensation liability for medical treatment unless there is an injury. When the lien claimant, rather than the injured employee, litigates the issue of liability it stands in the shoes of the injured worker and must establish the compensability of an injury by a preponderance of evidence.

The Board found no substantial evidence and disagreed with the Judge's conclusion that the defendant's notice of denial was an admission that the applicant had an injury. At most it was an acknowledgment that an incident occurred.

The WCAB did remand the matter for further consideration on the issue of whether medical legal costs could still be allowed under Labor Code § 4621.

Tapia v. Skill Master Staffing and Liberty Mutual Insurance Co. (2008) (en banc)

In an en banc decision involving a surgical center lien, the WCAB clarified the burden of proof and evidence required to rebut the claim of "reasonable" billing.

The underlying case was settled by way of Compromise and Release with the only remaining issue being that of a surgical center lien in excess of \$23,000. The defendant paid a little over \$1,600 of that bill, leaving a balance of almost \$22,000.

This matter proceeded to trial and the lien claimant entered into evidence the operative report and their actual billing. The parties stipulated that the defendant's expert would indicate that the average charge for an inpatient stay for such a procedure would be about \$5,700 and that the new fee schedule for this procedure would be \$1,770. Medicare's fee for such a procedure would be \$832 and the Fee Schedule for hospital-based outpatient surgery centers would be little over \$1,200.

Neither party presented evidence regarding fees accepted by other outpatient surgery centers in the same geographic area.

The Worker's Compensation Judge found that the reasonable value of the services was \$4,700, less credit for previously paid sums.

The lien claimant argued that under the Kunz case (Kunz v. Patterson Floor Coverings Inc. (2002) 67 CCC 1588) (en banc) the bill from the lien claimant constituted prima facie evidence that the amount claimed was reasonable and that the defendant had the burden to prove what other outpatient surgery centers in the same geographic region accepted to justify awarding less than the full bill.

The WCAB rejected this approach stressing that all lien claimants, including surgical centers, have the affirmative burden of proving that its lien is reasonable and that the billing in and of itself does not establish that the claimed fee is reasonable. Rather, it is only evidence of what it usually accepts for the services rendered and what other medical providers in the same area usually accept. These two factors are not necessarily dispositive, particularly when the lien appears to be unreasonable on its face.

The Kunz case does not limit what rebuttal evidence may be presented although it does describe that such evidence may consist of what other inpatient or outpatient providers accept for the same similar or similar services. The Board must take into consideration a number of factors and the defendant or lien claimant may present any relevant evidence concerning the issue. The Board specifically overruled the case of Universal Building Services v. WCAB (Yturbe) (2006) (writ denied) 71 CCC 655. That case found that the billing must be accepted as proof of a reasonable fee if the defendants do not present evidence of what other facilities accept for the same or similar services.

In the instant case, the WCAB found that the evidence presented by the defendant was enough to overcome the lien claimant's attempt to carry its burden of proof on the issue of reasonableness. The WCAB found that billing nearly \$18,000 more than the amount allowed by law for inpatient hospitals in the same area was unreasonable on its face. They also indicated that although the Fee Schedule was not dispositive, it is not irrelevant.

The WCAB found that the lien claimant failed to carry its burden of proving that its charges were reasonable.

MPN

Palm Medical Group Inc. v. SCIF (2008) 161 CA4th 206, 36 CWCR 55, 73 CCC 352

In a case coming out of the 1st District, the Court of Appeal reinstated a million-dollar plus award against State Compensation Insurance Fund in favor of a Fresno medical group which claimed that defendant's refusal to include them in their PPN (akin to an MPN) violated the fair procedures doctrine.

In 1996 State Compensation Insurance Fund created a PPN program. Palm Medical Group in Fresno was founded in 1995 and in 1998 contacted State Compensation Insurance Fund seeking admission to the PPN. An individual from State Compensation Insurance Fund toured the facility and met with the staff, but advised Palm that she would not recommend it being included because there was no need for another network provider in northwest Fresno. Palm once again requested to be included in 2001 and was rejected again in 2002.

In 2003 Palm sued State Fund and after a month-long jury trial a verdict was returned in favor of Palm. The jury concluded that SCIF controlled a large part of the market and that their stated reasons for rejecting plaintiff were arbitrary and unreasonable and had Palm been treated fairly they would have been admitted to the PPN and awarded damages of \$1.1 million. State Fund moved to set aside the judgment and the trial judge agreed, entering a new judgment in State Compensation Insurance Fund's favor.

The Court of Appeal reversed, applying the common-law right to "fair procedure." The obligation to comply with fair procedure arises when an insurer possesses power that is substantial such that the removal significantly impairs the ability of an ordinary competent physician to practice medicine. (citing Potvin v. Metropolitan Life Ins. Co. (2000) 22 C4th 1060.

The Appeals Court rejected defendant's argument that Potvin only applied to removal decisions and not exclusions of persons who were never admitted.

The court then indicated that the judgment notwithstanding the verdict may only be granted if the verdict is not supported by substantial evidence and they felt that there was such evidence present.

NEW RATING SCHEDULE

Boughner v. Zurich America (2008) 36 CWCR 111, 73 CCC 854 (en banc)

The Board, in a unanimous decision, held that the employee hadn't been able to demonstrate that the AD's adoption of the rating schedule was arbitrary, capricious or inconsistent with Labor Code § 4660(b)(2).

Quasi--legislative acts of administrative agencies are accorded the most deference on judicial review. There is a strong presumption of validity. An administrative regulation is presumptively valid. If there is a reasonable basis for it, the Board will not substitute its independent judgment. The Board viewed its task as limited to deciding whether the regulation was within the AD's authority and reasonably necessary to effectuate the purpose of § 4660.

Applicant argued that the new schedule was invalid because the administrative director had failed to base the DFEC adjustment on data and findings from the RAND report and on data from additional empirical sources. These contentions were rejected by the Board, noting that the AD had testified to the state Senate that she did in fact use data from the RAND report. In summary, the Board reiterated that it was required to defer to the AD's expertise and was precluded from superimposing its policy judgment on the AD's actions or from reviewing the wisdom of such actions.

Although the opinion by the Board as well as by the trial judge were both learned and detailed, there is no clue in the lengthy exegesis as to what the nature of independent testimony needs to be from a rehab expert to rebut or otherwise challenge the prima facie evidence of the rating schedule.

The statute does not talk about each individual's loss of earning capacity but rather empirical data that "aggregates" the "average percentage" of long-term loss of income resulting from each "type" of injury for "similarly situated" employees.

What do those words mean and how is vocational testimony meant to deal with such non-specific, statistical concepts? Clearly something other than the specific factual loss of earning capacity for a particular worker was meant by Labor Code § 4660(b)(2). What is that "other"? Until that is determined by the Board and the courts, the parties are going to be wasting an incredible amount of time and money in useless, unfocused testimony and rehab experts are going to praise the emperor and his new clothes all the way to their respective banks in this dark, recessionary time.

OLD/NEW?

Some background:

§4660(d) has three exceptions to escape using the new schedule for pre--January 1, 2005 injuries. In each of these instances if the described action takes place before January 1, 2005 the old schedule applies, when:

1. The employer is required to provide a notice of the potential right to permanent disability required by Labor Code §4061;
2. There is a comprehensive medical-legal reports indicating the existence of permanent disability; or
3. There is a report by a treating physician indicating the existence of permanent disability.

The first of these exceptions was taken care of in Costco Wholesale v. WCAB (Chavez) (2007) 151 CA4th 148, 35 CWCR 147, 181, 72 CCC 582, following up on Pendergrass v. SCIF (2007) 35 CWCR 124, 72 CCC 456 ("Pendergrass II"), to indicate that the notice requirement is measured from the date when TD ended and not when it began. That put a lot of cases into the new schedule which would otherwise have been kept under the older schedule.

However, with regard to the two other exceptions, the courts have been puzzlingly liberal in finding that the exceptions apply.

Vera v. WCAB (2007) 154 CA4th 996, 35 CWCR 233, 72 CCC 1115

The first case to deal with these exceptions was not supremely expansive. It found that there could be no indication of the existence of permanent disability until an applicant was actually permanent and stationary and could have his or her rating factors described. That created a bright line to separate out which cases would go under the old schedule and which under the new.

However, all the cases which have come down from the Courts of Appeal since then have indicated that the Vera is wrong and that for a disability to be permanent, sufficient to give an indication of the existence of PD, an applicant does not have to be permanent and stationary.

One could inject a modicum of cynicism into the commentary and say that the application of the law in these cases appears very much result-oriented, rather than being a purely objective analysis of the statute.

Genlyte Group LLC v. WCAB (Zavala) (2008) 158 CA4th 705, 36 CWCR 1, 73 CCC 6

The Second Appellate District Court of Appeal rejected the holding in Vera v. WCAB (2007) 154 CA4th 996, 35 CWCR 33, 72 CCC 1115.

Applicant sustained upper extremity injuries in a 2001 specific and on a cumulative basis through 2003. Surgeries were performed in 2003 and in 2004. Additional surgeries were sought and in September 2004 the treating doctor stated that in his opinion the applicant had permanent disability but he would determine its extent after further evaluation. However, the applicant was not found permanent and stationary until October of 2005.

The case went to trial and the Judge awarded permanent disability under the old schedule based on the original Baglione decision. That was affirmed by the WCAB and defendant sought review.

In its decision, the court held that there must have been a comprehensive med legal report stating that permanent disability existed before 1/1/05. However the court rejected the Vera court's opinion that found that the condition must be permanent and stationary for any report to indicate the existence of permanent disability. The court did not find the concepts of "permanent and stationary status" and "permanent disability" as interchangeable. It specifically indicated that a physician is not "precluded from reporting that permanent disability exists prior to the time the injured worker has reached permanent and stationary status or the extent of ratable permanent disability is known."

The case was remanded to the WCAB to decide whether or not the reports are substantial evidence of the existence of permanent disability and then to decide whether or not the old or new rating schedule applied.

Zenith Insurance Company v. WCAB (Cugini) (2008) 159 CA4th 483, 36 CWCR 29, 73 CCC 81

In another opinion commenting on which rating schedule to use, the 2d District affirmed its prior decision in Zavala that the applicant's condition need not be permanent and stationary to indicate the existence of permanent disability. However, they went on to indicate that the medical report establishing the existence of permanent disability before the end of the year must be substantial evidence based on the entire record.

In June 2004, the applicant was diagnosed as having a disc bulge. In October 2004, the treating physician recommended a neurosurgical evaluation. The neurosurgeon indicated on December 23 that he could see no other option but to perform surgery on an extruded fragment. In a brief report of December 28, 2004 the treating physician indicated that there was reasonable medical probability that permanent disability existed but it would be described later.

The applicant underwent back surgery in March of 2005 and was found to be permanent and stationary in December of 2005. Under the 1997 schedule his disability amounted to 42% and under the 2005 schedule it was 13%. Temporary disability was paid from June 19, 2004 through December 2005.

The WCAB originally awarded the 42% applying the 1997 schedule on the grounds that the defendant was required to give a benefit notice when TD commenced thus giving rise to the notice of exception of 4660(d).

This was appealed and eventually the Court of Appeal rejected that argument and concluded that the notice exception in § 4660(d) was not satisfied by the defendant's beginning TD payments in 2004 because the last TD payment was made not made until 2005. They annulled the case for that reason.

They then turned to the existence of permanent disability and concluded that a determination of whether the treating doctor's three sentence December 28, 2004 report provided substantial evidence indicating the existence of PD needs to be determined by the WCAB as to whether or not it is substantial evidence in light of the entire record. Since the WCAB did not make a specific rule ruling on the PD exception the Court remanded the case for the WCAB to do so.

Virginia Surety v. WCAB (Wragg) (2008) 36 CWCR 4, 73 CCC 75 [nonpub.]

Applicant got a 61% rating based on the old schedule. He had a back injury in 2003 and the primary treater issued a progress report on December 22, 2004, stating that although applicant's condition was not yet P&S, he would be left with residual PD. This was sufficiently substantial evidence to satisfy the Court of Appeal.

Tenet/Doctors Medical Center v. WCAB (Reddrick) (2008) 36 CWCR 59, 73 CCC 329 [nonpub.]

The First District Court of Appeal in San Francisco favored the analysis in **Zavala** and **Cugini** and disavowed the **Vera** finding.

Applicant had a right upper extremity injury in March 2003. She saw a panel Qualified Medical Examiner in October 2004 who found that she had tendinitis and epicondylitis. He recommended surgery but in the absence of surgery, he said she could be considered permanent and stationary, although if she wanted surgery, P&S status would occur some four to six months after the surgery. The QME provided work restrictions. Applicant underwent surgery three months later. In 2005 the same QME declared her P&S with disability factors "equivalent to my previous recommendations."

The appellate panel indicated that it is only necessary that a pre-2005 report indicate that applicant has suffered a permanent impairment of earning capacity, the permanent impairment of the normal use of a body part or a permanent competitive handicap in the open labor market.

The court indicated that there was substantial evidence that PD existed based on the doctor's October 2004 report. The fact that the doctor repeated factors of disability in 2005 which he described back in 2004 illustrated that the doctor had concluded at the earlier date that applicant would be permanently disabled.

The court further felt that the doctor's pre-2005 report said that applicant could be deemed P&S if she opted not to undergo the surgery. Up to the point she exercised that option, she was P&S and had the factors of permanent disability described.

Newlands v. WCAB (2008) 36 CWCR 165, 73 CCC 1010 [nonpub.]

The applicant suffered cumulative injury to her upper extremities, leading to multiple surgeries before 2005 with treater medicals indicating that further treatment might improve her hand function, but only partially. The QME challenged the treaters' conclusions that she suffered CRPS, but felt her 2003 surgeries almost automatically warranted PD. For the court, this was sufficient to indicate the existence of PD before January 1, 2005, though some later issues arose about her credibility and the extent of her disability because of activity caught on video.

Virgina Surety Co. v. WCAB (Echelard) (2008) 36 CWCR 196, 73 CCC 1218 (nonpub.)

The Court of Appeal found that for an injury of 10/29/04, a report late that year by a treating physician supplemented by deposition testimony "clarifying" the doctor's position in 2007 was sufficient to prove the indication of the existence of permanent disability under Labor Code §4660(d) and bring this case under the older rating schedule.

Applicant was a construction worker who suffered a 20 foot fall late in 2004. His treater wrote in December 2004 after a multiple body parts for which disabling limitations were expected. However applicant was clearly not stabilized at that point.

The treater's deposition was taken in July 2007, at which point he indicated that based on the history he had as well as the x-rays and CT scan back in late 2004, future PD was indicated. The Court concluded that his deposition statements, considered in terms of reasonable medical probability, provided substantial evidence that applicant showed indications of the existence of PD back in December 2004 when the report was written. There is no authority that a pre-2005 report must be construed within its "four corners" and that the WCAB cannot consider a later explanation of the report's meaning from the doctor who wrote it.

PENALTY

Ramirez v. Drive Financial Services and One Beacon Insurance Company (2008) (en banc)

The WCAB addressed issues involving Labor Code Sections 5814 and 5814.5.

The applicant's claim was settled by way of Compromise and Release which was paid late. The applicant's attorney notified defendants of the late payments by several letters and requested penalties. The defendant, without any award, paid penalties equal to 10% of the Compromise and Release and attorney's fees. The defendants did not withhold any attorney's fees.

The applicant filed the penalty petition asserting that defendants should have paid the maximum penalties for the delay (either 25% or \$10,000) for each of the alleged delays. Additionally because Defendants underpaid the penalties they now owe a 25% penalty, plus interest, against the underpayment. The applicant's attorney also requested fees pursuant to §5814.5.

The Worker's Compensation Judge issued a finding that no further penalties were owed for late payments, but that a 10% fee for applicant's attorney was warranted. (Presumably because the defendants failed to withhold attorney's fees from the penalties they paid.) The judge specifically indicated that while the statute authorizes a penalty of up to 25%, it affords discretion to award a lesser amount. The judge declined to award a fee pursuant to §5814.5 finding that it only applied to dates of injuries on or after January 1, 2003.

This matter was appealed.

The WCAB, in an en banc decision, specifically found that the penalties contained in Labor Code Section 5814 are not mandatory and that the judge has discretion in deciding how much to award as a penalty. The judge is to "accomplish a fair balance and substantial justice between the parties".

The WCAB engaged in a lengthy analysis of the purposes behind the penalty statute, i.e., to pay benefits promptly by making delay costly and to ameliorate the economic hardship on the injured worker that results from the delay in the provision of benefits.

The factors to be considered include, but are not limited to:

- 1) evidence in the amount of the payment delayed;
- 2) evidence of the length of delay;
- 3) evidence of whether the delay was inadvertent and promptly corrected;
- 4) evidence of whether there was a history of delayed payment or, instead, if the delay was a solitary instance of human error;
- 5) evidence of whether there was any statutory, regulatory, or other requirement (e.g., an order or stipulation of the parties) providing that payment was to be made within a specific number of days;
- 6) evidence as to whether the delay was due to the realities of the business of processing claims for the benefits or the legitimate needs of administering workers' compensation insurance;
- 7) evidence of whether there was institutional neglect by

the defendant, such as not enough adjusters; 8) evidence as to whether the employee contributed to the delay; and, 9) evidence of the effect of the delay on the injured worker.

Since the Judge in this case did not offer an explanation as to why he thought the amounts paid by defendants were appropriate, the matter was remanded back to the Judge for a detailed discussion of same.

The WCAB went on to indicate that the principles enunciated in Christian v. WCAB (1997) 15 C4th 505, 25 CWCR 141, 62 CCC 576, still apply to the new Section 5814. They specifically found that in this case that the defendant's voluntary 10% payment in the absence of a WCAB order was not a legally significant intervening event. However, that matter was remanded back to the Judge as well to make specific factual findings in this regard.

Finally the WCAB specifically found that §5814.5 does apply to injuries occurring before the January 1, 2003 effective date when the acts complained of were after that date. They went on to indicate that the attorney fee under §5814.5 shall be in addition to applicant's recovery based on a reasonable number of hours expended in enforcing the prior award of benefits at a reasonable hourly rate. They stressed, however, that those fees are payable only when there was a prior award of benefits.

[The Board does not discuss NUMMI v. WCAB (Gallegos) (2006) 141 CA4th 1533, 34 CWCR 214, 71 CCC 1037, which allowed a defendant to pay only a 10% add-on when it discovered its non-payment (through a letter from applicant's attorney) and made payment in about 45 days after the "discovery." This satisfied Labor Code section 5814(b). Is a penalty petition or a letter sufficient to cut off that 90 day "discovery" grace period?]

PROCEDURE

County of Orange v. WCAB (Lean) (2008) 36 CWCR 35, 73 CCC 1. (nonpub.)

In a non-published opinion the 4th District annulled an Order of the Board dismissing a petition for reconsideration as being untimely filed. This is yet another one of these cases that come out every year where the petition for reconsideration is filed on the second floor, the local district office in San Francisco, when it should have been directed to the ninth floor which is the reconsideration unit. By the time the petition reached the ninth floor it was untimely.

In this particular case since the defendants were given incorrect information by a state employee the WCAB changed its mind via letter after the appeal had been filed. However the court did indicate that the merits of the petition should not be denied due to administrative error.

Beal v. Royal and SunAlliance (2008) 36 CWCR 87, Decision After Reconsideration

The applicant sustained an admitted industrial injury and entered into stipulations with defendant that ordered, inter alia, further medical treatment. Subsequently the defendant's insurer changed its claims administrator but did not request that the official address record in the applicant's claim be changed.

A lien claimant filed a lien in 2007 which was set for status conference. The defendants did not appear at the status conference. The Judge took the testimony from the lien claimant that they had served the defendants at the address on the official address record.

The judge found that the defendant had failed to appear without good cause and awarded lien claimant the full amount of his claim and imposed penalties as well as a \$750 sanction. On January 3 the order was mailed to the address on the official address record but was eventually faxed to the defendant's claims administrator on January 31. On February 15, defendant filed a petition for reconsideration.

The Board rescinded the award initially finding that the petition was not untimely because it did not have notice of the January 3 order until it was faxed to them under January 31. They specifically found the defendant was not under an obligation to update the official address record while the case was inactive.

The panel further concluded that the defendants had been denied due process because they failed to receive notice of this status conference. Moreover the judge exceeded her authority when, without notice to the defendant, she transformed a status conference into an evidentiary hearing. Pursuant to DWC Rule 10562(c), when a party fails to appear at a hearing the Judge's power only includes taking the case off calendar or continuing it to another date. There is no authority for the Judge to convert a status conference into an evidentiary hearing and impose sanctions without notice.

Target Stores v. WCAB (Sollars) (2008) 36 CWCR 8, 73 CCC 56 (nonpub.)

The applicant sustained an admitted injury in May of 1991 and benefits were provided with a stipulated award issuing in 1994. The parts of body listed were the applicant's right elbow and arm. However, paragraph 8 of the stipulations indicated that they were based on the AME report of Dr. Chittenden with a rating that included a spinal guideline. The award specifically provided benefits as set forth in paragraph 8 of the Stipulation.

During the years following the defendant did pay for treatment to the right elbow, arm and back.

However with a change in administrators, the applicant was advised that defendant would no longer pay for treatment to the neck because it was not listed in the Award.

In 2005, the applicant filed a Petition to Reopen to a correct a clerical error.

After a hearing, the judge issued a decision amending the Findings and Award to include the neck. Although the WCAB had lost jurisdiction to reopen the case, it found that the omission of the neck from paragraph 1 of the stipulation was a clerical error.

The judge was affirmed by the WCAB and the defendant sought review.

The Fifth District upheld the WCAB finding that it had power to control and administer its continuing award of medical care. Although the petition was mislabeled as one to reopen under Labor Code § 5803 it was appropriate for the WCAB to deem it a Petition to Enforce an Award. The court rejected the defendant's petition and awarded attorney's fees under Labor Code § 5801.

SCIF v. WCAB (Sandhagen) and **Sandhagen v. WCAB** (2008) 44 C4th 230, 36 CWCR 133, 159, 73 CCC 981

The Supreme Court held that an employer must follow the Utilization Review provisions and timetables of Labor Code § 4610 when deciding whether to approve or deny a request for treatment, and does not have the safety valve of using the dispute resolution provisions of § 4062, as held below. Only the worker, not the employer, may use §4062 to object to an employer's decision on medical care. Is the worker *required* to use section 4062? [See Willette v. WCAB (2004) 32 CWCR 287, 69 CCC 1298 (en banc).]

Questioning the timeliness of Utilization Review denials is going to increase substantially (and has already done so) as applicants' attorneys are going to be seeking out lax UR practices and getting treatment provided to their clients when Utilization Review does not timely deal with requests for treatment, along with requests for attorneys' fees to enforce an award of treatment.

SECTION 4850

Jimenez v. Kings County (2008) 36 CWCR 117, Decision after Reconsideration.

A Board panel ruled that an award of full salary in lieu of TD per Labor Code § 4850 requires that the weekly payment be made at the salary the officer would then be earning on the job were he not on leave, not the amount of earnings on the date of injury.

Applicant, a probation officer, was hurt on 6/5/07. His weekly salary at that point was roughly \$1025 per week. He did not have any temporary disability until the end of 11/07, when he was earning roughly \$850 per week after being demoted. A judge awarded benefits based on earnings of the date of injury. On reconsideration, a unanimous panel pointed out that the language of § 4850 refers to a leave of absence, without loss of salary in lieu of TD which would be payable for the period of the disability. The panel interpreted that language to mean that the weekly amount to be paid is the amount of salary that would have been paid during that period if the officer had not been off. The purpose of § 4850 is to replace only the salary that the employee loses because of his disability.

Earning capacity is not the basis of the amount to be paid under § 4850.

STATUTE OF LIMITATIONS

Earthgrains Co. v. WCAB (Hansen) (2008) 36 CWCR 168, 73 CCC 1000 (nonpub.)

Applicant, a route salesman, worked for the employer for 14 years until 6/02. Over that time he had three stipulated awards, one for the right knee and two for the back, all specific injuries. Almost 3 years after retiring, he filed a claim for cumulative trauma to both knees, upper extremities and his back. At trial, he testified that he retired because he had to undergo back surgery. It was done in 7/02. The trial judge found a cumulative claim timely, gave applicant more than two years of temporary disability and a 49% PD award after apportionment. The award was amended to find two more years of temporary disability at its beginning and found the date of injury to be 5/05, the date of concurrence of disability and knowledge that the injury was caused by employment per Labor Code § 5412.

The Board denied reconsideration, adopting the judge's report and recommendation.

The court found no knowledge on the part of applicant that he was suffering from a new cumulative. There was a report back in 9/01 by a treater suggesting a new cumulative. The report however was only sent to the carrier and applicant never saw it and did not recall the doctor telling him his work contributed to his problems. He also testified that he did not know what "cumulative trauma" meant before he saw his attorney in 2005. He just expected his employer to take care of his problems as it had in the past. He didn't do anything more on the cases until the carrier said it was closing its claim.

The court said that the employer, which may not have had any knowledge of the worker's condition, could not separate its knowledge from that of its insurer. If the records and reports clearly indicated a new cumulative injury, then it was the insurer's responsibility to provide applicant with a new claim form on behalf of the employer. If the insurer can claim that it did not have the knowledge to indicate it was paying for treatment for a new cumulative claim, then how could it charge the employee with such knowledge?

The only place where the court supported the defendant had to do with the permanent and stationary date which the judge found to be in 8/06. There was an orthopedic report at that time indicating that applicant was more than a year past right knee replacement and even further along since a left knee replacement. The doctor says at that point that applicant's condition "is permanent and stationary." However, the fact that the QME stated that applicant is permanent stationary is not the same as saying when was when that status was reached. The court was also troubled that the evaluator felt that it was "over one year" since applicant's last surgery when a fact it was three years since that surgery and other doctors and found applicant permanent and stationary back in early 2004. The case was remanded for further proceedings on a permanent and stationary date only.

The Court of Appeal ruled that an injured painter's 1997 back injury was not barred by the statute of limitations when filed in 2004 because the employer failed to give applicant notice of his rights. Further, CIGA was estopped to assert the statute of limitations because of its delay in deciding the injury is a covered claim. Lastly, CIGA failed to show that the injured worker had actual knowledge of his rights sufficient to end the tolling period.

The injured worker had an accepted 1996 injury. He suffered yet another injury in 1997 which he advised the employer of but was not given any notice of his potential rights. This injury had occurred before the beginning of a shift and the employer had dissuaded his pursuing it. In 1999, he hired an attorney on the 1996 claim and told doctors about the 1997 incident. In 2000 the insurer became insolvent and CIGA involved itself in the case. In 2002, the 1996 case was ordered off calendar for applicant's attorney did file for the 1997 injury. He finally got around to that in 3/04.

After trial, the judge found 43% PD for the 1997 injury, ruled against a statute of limitations defense, finding that the defendants became aware of the 1997 injury in AME reports of 2001 and 2002, and failed to provide notice at that time. It didn't matter that the applicant had an attorney because CIGA did not admit coverage for the injury until 5/03. That conduct delayed the application been filed, estopping CIGA from raising the statute of limitations defense. The Board panel approved the judge's decision 2-1, with Commissioner Caplane dissenting.

The Court of Appeal noted that although applicant was receiving benefits for his 1996 injury, CIGA provided no evidence that applicant knew the 1997 injury was potentially a compensable claim, since the injury happened before a shift and the employer convinced him that the incident was not work-related. Although the attorney may have known that this was a potentially compensable claim, his knowledge is not imputed to the worker where actual knowledge is required. There was a 1999 medical report which talked about the 1997 injury as occurring while at work but no evidence that applicant had ever seen the report. Further, in 2002 a continuance was granted, to allow for filing on the 1997 claim, but the hearing record does not show whether applicant was present or otherwise knew why the continuance was granted. This only indicates the lawyer believed that the 1997 injury was compensable, not the applicant's actual belief that he had rights for that 1997 injury.

Further, CIGA was found estopped generally because its conduct allegedly caused a delay. However, on reconsideration it did not seek a more specific finding on the issue and thus waived it.

A partially dissenting Justice felt that the attorney's knowledge about the potential claim was sufficient to bind the worker. However, he felt that estoppel was appropriate and therefore concurred in the court's decision.

TEMPORARY DISABILITY CAP

Brooks v. WCAB (2008) 161 CA4th 1522, 36 CWCR 79, 73 CCC 447

The court of appeal has affirmed a Board decision that industrial disability leave benefits must be included when calculating the two-year TD cap under Labor Code § 4656(c)(1). The court found that IDL is statutorily defined as the equivalent of TD and there is no reason why the two-year cap would not apply equally to both types of benefits.

The injured worker was a correctional officer in Tehachapi. She suffered an injury in 10/04, got IDL benefits for a year and then a year of TD. She was still temporarily disabled when the employer stopped providing TD benefits in the late 10/06. The trial judge found that IDL benefits paid under Government Code § 19870(a) are functionally equivalent to TD. A Board panel denied applicant's recon petition. The court of appeal rejected applicant's position that she should get IDL plus up to 104 weeks of TD thereafter. The court pointed to §19870(a) which specifically states that IDL "means temporary disability." Finding the statute unambiguous, there was no need to resort to the legerdemain of Labor Code § 3202.

The court refused to find the analogy to § 4850 benefits as the equivalent of IDL benefits. In City of Oakland v. WCAB (Aisthorpe/Watson) (2007) 72 CCC 249 (writ denied), the Board had held that payments under Labor Code §4850 were not subject to the two-year TD cap. §4850 benefits differ from IDL benefits. The latter are only paid during TD, while § 4850 benefits are payable regardless of whether the applicant is eligible for TD or PD benefits. Further, the Government Code has specifically stated that IDL means TD. There is no similar language in §4850.

[See also Wiley v. WCAB in this summary, finding that enhanced IDL has no better luck than regular IDL in beating the two-year cap.]

Wiley v. WCAB (2008) 36 CWCR 107, 73 CCC 604 [nonpub.]

The Court of Appeal affirming a Board panel decision held that payment of enhanced Industrial Disability Leave (IDL) benefits count toward the two year limit on TD in Labor Code § 4656(c)(1). The court found the case analogous to Brooks v. WCAB (2008) 161 CA4th 1522, 36 CWCR 79, 73 CCC 447, which it held that regular IDL was the equivalent of TD for purposes of the two-year statute.

Applicant, a corrections officer was injured in 12/04 after being assaulted by an inmate. He got enhanced IDL, a benefit payable to certain state employees injured by inmates, under which he got a year of full net

take-home salary. Thereafter he collected temporary disability for an additional year at which point the adjuster stopped benefits because of the two year cap. He contended that he was still temporarily disabled and entitled to two years of TD after enhanced IDL ended. The trial judge felt that IDL was more like §4850 benefits than temporary disability and awarded ongoing TD. A Board panel unanimously reversed the judge.

The Court of Appeal pointed out that state employees are limited to a maximum of two years of combined forms of TD. Government Code section 19870(a) states that IDL means TD. The only statute which distinguishes enhanced IDL from regular IDL it is Government Code §19871.2, which only talks about the amount to be paid and makes no distinction about these being two different kinds of benefits. The court refused to consider IDL payments under the appropriate Government Code sections as the equivalent of § 4850 salary continuation.

Dupard v. Amerisource/Bergen Corp. (2007) 36 CWCR 18

The applicant filed a claim alleging bilateral plantar fasciitis and went off work in April 2005. He received unemployment compensation benefits from the EDD beginning from that point. After a hearing, the Judge found that applicant's condition was caused by his work and awarded temporary disability beginning April 26, 2005 and continuing indefinitely. The Employment Development Department was allowed a lien for its payments and the accrued compensation was paid on October 20, 2006 and payments of continuing TD then commenced.

In April of 2007 defendant filed a Petition to Terminate Liability for Further TD payments alleging that as of April 27, 2007 they would have paid 104 aggregate weeks of temporary disability under Labor Code § 4656. The WCJ found that the date of commencement of temporary disability was October of 2006 and denied the Petition to Terminate.

The defendant sought reconsideration which was denied by the Workers' Compensation Appeals Board based on the Judge's Report and Recommendation.

The Judge, in his report, indicated that the 104 weeks of aggregate temporary disability began when the first payment of TD was made, citing Hawkins v. SCIF (2007) 35 CWCR 183, 72 CCC 807. Here the payments were not made until October of 2006 and petitioners had not paid 104 weeks of temporary disability since that date.

The defendants had also argued that the payment of temporary disability began when Employment Development Department made the first payment of UCD benefits. The Judge found that UCD benefits are not the same as temporary disability, nor are they paid by the defendant. Hence, that argument was rejected as well.

Mt. Diablo Unified School Dist. v. WCAB (Rollick) (2008) 165 CA4th 1154, 36 CWCR 194, 73 CCC 1212.

The First District Court of Appeal ruled that benefits paid under Education Code §44043 are akin to temporary disability payments and subject to the two year payment limitation of Labor Code §4656(c)(1), overturning a Board panel decision to the contrary.

Applicant was a special education assistant who had an industrial injury in 6/04 to her right leg and back. The claim was accepted after some initial dispute, and applicant was paid for periods of temporary disability on a continuing basis.

In 2/07, defendant asked the Board for an order terminating further TD liability, indicating that the first disability payment to applicant had been made in 2/05.

After applicant objected, the parties stipulated that applicant had received more than 85 weeks of "Education Code" benefits, and seven or so weeks of temporary disability. (Applicant had also received more than 22 weeks of benefits from EDD which was not considered in any of these calculations.)

Per Education Code §44043, an injured worker receiving temporary disability has her benefits supplemented up to her normal wage or salary, less appropriate deductions. These additional benefits continue as long as the employee has available sick leave, vacation, compensatory time off or other paid leave available.

The trial judge's analysis was that Education Code benefits are not conferred upon the employee by Division 4 of the Labor Code and are thus not TD. On reconsideration, the Board panel agreed and found that such Education Code benefits do not equate with temporary disability for purposes of the two year cap.

The Court of Appeal held that the statute was unambiguous. Education Code benefit payment is contingent on the payment of temporary disability under the comp system. It follows that the date temporary disability payments begin can be no later than the date of first payment under Education Code §44043. Each subsequent payment under the Education Code is contingent on receipt of a TD check and consists, in part, of temporary disability benefits. The fact that this particular school district issues a single check combining temporary disability and leave benefits does not change the essence of the underlying payments.

In this instance, the district did not follow the exact procedures stated in the Education Code which would have required a TD check going directly to applicant which would then be credited against the overall salary payment or endorsed over to the employer before payment of full salary. Here the third-party administrator sent TD checks directly to the employer which then sent the appropriate full salary check to the injured worker. This deviation from procedure was immaterial, according to the court.

Lastly, the court noted that §44043 payments are not analogous to salary continuation under Labor Code §4850. These are quite distinct provisions. § 4850 allows for leave of absence while disabled, "whether temporarily or permanently," without loss of salary for a one year period with salary payment "in lieu of" TD payments. §44043 provides for accumulated leave payments in addition to temporary disability and

these are contingent on receiving TD benefits. These payments end when the accrued leave time is exhausted. Per the court, "§44043 provides a different and inferior benefit than Labor Code §4850."

The Board's opinion was annulled and the case remanded for further proceedings consistent with the Court's opinion.

Foster v. WCAB (2008) 161 CA4th 1505, 36 CWCR 82, 73 CCC 466.

This case deals with the two year cap on temporary disability benefits in Labor Code § 4656(c)(1) when dealing with overlapping temporary disability resulting from two injuries.

Applicant hurt his right shoulder in late February 2005. He went back to modified work two weeks later. He suffered yet another injury to this same shoulder, his neck and right elbow in mid-April and was off work the next day and thereafter. He had arthroscopic shoulder surgery in mid-September 2005. He was examined by an AME in March 2007 who reported that the shoulder and elbow conditions were permanent and stationary by September 2006, though the neck was not. TD was paid from April 14, 2005 through April 14, 2007 when it was terminated per the two-year cap in § 4656(c)(1).

The trial judge found, in May 2007, that the first injury caused temporary disability from April 26, 2005 through September 25, 2006. Since TD could not run concurrently, TD from the second injury was payable from September 26, 2006 to the present and continuing. A Board panel reversed the judge, holding that TD periods do run concurrently if applicant is temporally disabled from both injuries at the same time. Applicant got TD benefits from mid-April 2005 to September 25, 2006 caused by both injuries, and from September 26, 2006 to mid- April 2007 because of the second injury, when the overall cap expired at two years from the date of initial payment.

The court found that SB 899 was meant to deal with the workers' compensation crisis and that the Legislature likely intended shorter periods of temporary disability to significantly narrow liability. If the Judge's interpretation prevailed, TD could be extended unpredictably. Such a result was not contemplated by the Legislature.

Hinchliff v. Sutter Health Corp. (2008) 36 CWCR 178, Decision after Reconsideration.

A TPA was not allowed to terminate temporary disability under Labor Code § 4656 after an injured worker underwent surgery in reliance on the adjuster's statement that TD payments would start up with surgery.

Applicant hurt her left knee while working as a nurse on 3/25/05. She was temporarily disabled intermittently through 12/07. Her treater operated on her knee twice. In 2007 she continued to have knee difficulties and a new primary treater took her off work and recommended a total knee replacement. In mid-October 2007, the defendant claims adjuster authorized surgery and told applicant her TD would be reinstated. She indeed got a notice 10 of 11 days later indicating temporary disability was being resumed back to mid-October and would continue until she became permanent and stationary. A day later, applicant discussed the matter with her recently obtained attorney and went ahead with the knee replacement on 12/12/07. A week later, defendant stopped temporary disability per section 4656's TD limitation of 104 weeks.

She claimed additional temporary disability and testified at trial that she wouldn't have submitted to the third surgery if she thought she was not going to be paid temporary disability because she could not afford going without income during surgery and convalescence.

The judge found that applicant entitled the temporary disability and defendant was estopped to assert § 4656.

In his report and recommendation on recon, the judge pointed out that estoppel required four elements: (1) that a party makes a representation of a material fact; (2) with knowledge of the fact; to (3) a party ignorant of the fact; (4) who is induced to rely on that representation. In this case there must be evidence that the employer provided erroneous information to the employee and that the employee relied on the representation to her detriment. That is exactly what happened here. The adjuster indicated that TD would resume and continuing while applicant was off work because of her knee surgery. That representation was erroneous because the defendant terminated TD right after the surgery. Applicant's uncontradicted testimony was that she would not have proceeded with surgery if she knew she wasn't going to get TD. Her reliance was detrimental because she could not work after the surgery.

In this case, the defendant argued that applicant's retaining counsel after a false representation is made prevents estoppel from applying. Here the §4656 limitation period had expired before defendant agreed to pay additional temporary disability. That statement about TD induced applicant to go ahead with the surgery. Having led applicant to believe that she would be paid TD related to the surgery, thereby inducing her to undergo the surgery, defendant could not be permitted to renege on its promise.