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IN THIS ISSUE...

THE CURRENT "VOUCHER" HAS COME A LONG WAY SINCE VOCATIONAL REHABILITATION

By Nicholas Pavlovich, Redding

The path to the current voucher system has evolved through many iterations ranging from an almost limitless rehabilitation plan to the modest benefit existing today. A brief overview of these previous attempts toward a system of vocational rehabilitation will provide a basis from which to make some comparisons and make some predictions on its future. In the interest of brevity, we will discuss only some of the iterations while trying to focus on the more significant events.

Not too long ago, beginning in 1975 but before 2009, stories were commonplace of injured workers being put through college while the insurance carrier paid the bill for tuition and books with a weekly benefit called "vocational rehabilitation temporary disability" (VRTD). It began as a rate equal to the temporary disability rate. In 1990 it was reduced to a lesser flat rate of $246 per week with a new name "vocational rehabilitation maintenance allowance" (VRMA). Those benefits could be provided for a year or more under a vocational rehabilitation plan developed by a "qualified rehabilitation representative"(QRR). There were many details that went into the development of such plans, and in many instances there was litigation concerning the "plan" before it was approved and implemented.

The employer was liable for any injury occurring as a result of the plan as a "compensable consequence" of the original injury. Curiously, even though the rehabilitation benefit itself could not be settled, any potential injury in the rehabilitation plan was capable of settlement at an additional cost. (*Rodgers v. WCAB* (1985) 50 Cal.Comp.Cases 550; *Carter v. County of Los Angeles* 84 LA 504567.)

In 1994 the Legislature first placed a cap on the total of rehabilitation costs of $16,000, and there were provisions to settle the benefit. This began the evolution of the vocational rehabilitation concept to reduce the expense of defending the plan process, and more so to curtail the previously significant vocational rehabilitation benefit to injured workers.

With the enactment of Assembly Bill No. 227, for injuries occurring on or after January 1, 2004, the "vocational rehabilitation" benefit was transformed into a "Supplemental Job Displacement Benefit" (SJDB) also known as the "voucher." This called for a tiered benefit system where the injured worker, after meeting certain qualifications, was entitled to receive a voucher ranging in value from $4,000

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NAVIGATING THE PANEL QME PROCESS:

Time Frames, Required Documentation, and Requests for Multiple Panels

By Alicia Valencia, Santa Monica

We've all been there. We receive a Claim Form DWC-1 or notification that the applicant filed an Application for Adjudication of Claim, and applicant's attorney submits their PTP report(s) finding, what else? TTD, industrial causation down to the toes, and a myriad of medical treatment recommendations. We need a medical-legal opinion to address either 1) industrial causation (Labor Code Section 4060), 2) permanent disability (Labor Code Section 4061), or 3) other medical determination made by the primary treating physician (Labor Code Section 4062). But with the ever changing regulations and procedures for requesting a panel list, the process for obtaining a panel QME is a labyrinth in itself. Below is a guide discussing recent case law and trends that should make navigating the QME panel list labyrinth a little smoother.

PROCEDURE AND TIME FRAMES

Requesting a Panel QME to Address Compensability

If you are requesting a QME panel to address compensability under Labor Code Section 4060(c), the post-SB 863 procedure to follow prior to requesting a panel is confusing. Do the parties need to send a letter to the opposing party advising of their **intent** to request a panel? Or can a QME panel be obtained after the claim denial notice is issued?

Labor Code Section 4060(c) indicates that in represented cases, a medical legal evaluation should be obtained through the procedure provided in Labor Code Section 4062, now Section 4062.2. Section 4062 however, refers back to Section 4060 providing that "no earlier than the first working day that is at least 10 days after the date of mailing of a **request for a medical evaluation pursuant to Section 4060** . . . either party may request the assignment of a three-member panel of qualified medical evaluators." (Emphasis added).

What is a "request for a medical evaluation pursuant to Labor Code Section 4060?"

Many practitioners interpreted that phrase to mean that after receipt of the carrier's notice of denial of the claim, the parties had to first send a letter notifying the other party of their **intent** to request a medical legal evaluation before requesting a panel QME list.

Others thought the above was much too similar to the previous AME offer letter requirement in Section 4062. Instead, they interpreted the new provisions to mean that the parties can request a panel QME list 10 days after the issuance of the carrier's claim denial notice.

Luckily, the Appeals Board clarified the procedure for requesting a panel under Section 4060 in *Bahena v. Charles Virzi Constr.* (2014) Cal. Wrk. Comp. P.D. Lexis 638.

The Board noted that as part of SB 863, the provisions of (then) Labor Code Section 4062 were amended to remove the language requiring the parties to send an AME offer letter. Despite this, the Board noted that post-SB 863, many practitioners were interpreting the new language of Section 4062 to mean that they had to advise of their intent to request a panel QME list.

The Appeals Board found that interpretation of Section 4062 flawed. They indicated that since Section 4062 refers back to Section 4060 and the Legislature did not specifically include language in Section 4060 requiring the other party be notified of the other's intent to request a medical evaluation, there is no such requirement.

They further added that by removing the requirement to propose an AME, the Legislature intended to make the request for a panel in represented cases more like the streamlined process in unrepresented cases. In those cases, the unrepresented employee is allowed to make their request for a panel upon receipt of the claim denial notice from the carrier.

Therefore, the Board concluded that in order to request a panel QME under Section 4060, the parties may do so 10 days (plus 5 for mailing) after receipt of the claim denial notice.

1. Requesting a Panel Within the First 90 Days?

Interestingly, the new regulations addressing online panel requests allow a request for a QME list to be made even before the claim denial notice issues.

Pursuant to 8 Cal. Code Reg. Section 30(d)(1) **after the filing of a claim form**, a panel QME request can be made **by the claims administrator** to determine whether to

PANEL QME PROCESS CONT.

deny or accept the claim **within the 90 day period for rejecting liability** per Section 4060 only.

The regulation does not state whether it applies only in represented or non-represented cases.

Ironically, while the regulation can be seen as providing the claims administrator the first bite at the apple, it can also have the effect of proving the applicant's attorney's case for them. In the foreseeable scenario, an applicant's attorney can sit back, let the claims administrator request a panel list, and wait for the report likely finding industrial causation to at least one of the pled body parts all within the first 90 days of the claim and without needing to obtain a treating physician report finding industrial causation.

Also, be wary of misinterpretation of this regulation. A panel list **can be requested by applicant's attorneys before the 90 days expire if the claim is already denied**. The regulation only prohibits them from requesting a panel list before the 90 days if the claim is not yet accepted or denied. In that situation, only the claims administrator can request a panel before the 90 days expires. We have seen cases in which the applicant's attorney requested a panel QME list within the 90 days but after the claim denial. The Medical Unit rejected the panel request because the 90 days had not yet expired. When that happens, a WCJ can and has overruled the Medical Unit and ordered a panel list to issue.

Ultimately, whether to request the panel list before the claim is denied or wait until afterwards is a strategic call that is made on a case by case basis.

2. Five days for mailing?

The prevailing view is based on the *en banc* Appeals Board decision of *Messelle v. Pitco Food, Inc.* (2011) 76 CCC 956 (en banc), finding the parties cannot make their panel QME request until the 16th day of mailing of their written AME proposal to the other party.

However, in the recent panel case of *Murray v. County of Monterey* (2015) Cal. Wrk. Comp. P.D. LEXIS 304 (not a significant panel decision) the Board found that the holding in *Messelle* applied to the old version of Section 4062 and that a request on the 15th day was valid.

The Board reasoned that the prior version of Section 4062 providing "if no agreement is reached within 10 days of the first written proposal that names a proposed agreed medical evaluator..." was not clear and required interpretation which the Court in *Messelle* provided.

The Board concluded that a request can now be made on the 15th day because the language in the new Section 4062 is clear and provides "the party desiring a QME panel may request one, '**at least 10 days after** the mailing' of a request for evaluation" under Sections 4060, 4061, or 4062. (Emphasis added). (*Murray* at *7).

The DWC website however, still follows the *Messelle* holding stating that an eligible QME panel request can be made on the 16th day and is considered premature if it is made before 15 days have elapsed.

Thus, while there is an argument that the request can be made sooner per the *Murray* case, to avoid delays of litigating the issue, most parties continue to follow the prevailing view based on the *Messelle* holding.

Time for Striking From the Panel QME List

In the recent case of *Razo v. Las Posas Country Club* (2014) Cal. Wrk. Comp. P.D. LEXIS 12 (not a significant panel decision) defendants alleged that applicant's attorney's strike on the 12th day from the date of assignment of the panel list by the Medical Unit, was untimely under *Messelle v. Pitco Foods, Inc.* (2011) 76 CCC 956 (en banc). There, the Court citing *Alvarado v. WCAB* (2007) 72 CCC 1142 (writ denied), held that the "+5 days for mailing" rule was triggered only by "service" of a document not by "assignment."

Applicant's attorney in *Razo* then argued that because the panel was sent to him by mail from the Medical Unit, 8 Cal. Code Reg. Section10507 applied granting him an additional 5 days for mailing.

The Board in *Razo* found in favor of applicant's attorney holding that "assignment" and "service" meant the same thing since the Legislature could not have meant otherwise.

The Legislature seems to put the above dispute to rest in the new regulations addressing online panel QME requests. Pursuant to Section 30(b)(1)(C), "within 10 days of **service** of the panel, each party may strike one name from the panel list." (Emphasis added).

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BACK TO THE PAST:
Board Sheds Light on Retrospective Nature of Utilization Review and Other Issues in *Belling v. United Parcel Service, Inc.*

By Julio Salazar, Pasadena

Obligations in a Retrospective Review

The WCAB determined in a panel decision, *Belling v. United Parcel Service, Inc.* that a defendant must submit prior Requests for Authorization ("RFA") to Utilization Review ("UR") if a case proceeds to a Priority Trial and a decision issues finding industrial causation.

Belling concerned a longstanding claim that had been heavily litigated and involved both a specific and cumulative trauma in which serious internal injuries were alleged, to include a brain aneurysm resulting in stroke-like sequelae. These two claims were determined compensable by way of a Findings and Award issued on April 12, 2013 that was upheld on reconsideration on June 21, 2013.

Prior to these findings, defendant received multiple reports and RFAs from the applicant's internal treater requesting treatment and care. Given that the claim was denied at the time the RFAs were submitted, Defendant deferred obtaining UR pending a compensability determination.

Subsequent to the case being deemed compensable, Defendant received another report and RFA from the internal treater dated January 21, 2014 again requesting the previously sought treatment and care. In response to this request, defendant issued a UR denial for these services on February 4, 2014.

The Board upheld a Findings and Award that determined that this UR was untimely pursuant to Labor Code Section 4600(h). In a lengthy and wide ranging decision, the WCAB also shed some light on the reasonableness and necessity of home healthcare, home assessment for modifications, need for a nurse case manager, need for transportation, need for stroke rehabilitation, and when communication between an applicant's spouse and a panel QME does not constitute impermissible ex parte communication. The WCAB also made it clear that Labor Code Section 5307.8 (schedule of fees for non Medicare covered services such as home healthcare) did not allow a defendant to take advantage of a marital relationship.

The Board noted that UR can be prospective, retroactive or concurrent pursuant to the language of Labor Code Section 4610 with the time frame for acting on such UR being governed by subsection (g). As to prospective or concurrent decisions, the Board noted that subsection (g)(1) required that UR cannot be conducted more than five working days from the receipt of the information reasonably necessary to make the determination. In no event can it be more than 14 days from the date of the medical treatment recommended by the physician. A retrospective UR is defined in Administrative Director Rule 9792.6 subsection (u) as "….utilization review conducted after medical services have been provided and for which approval has not already been given".

The WCAB noted that although Labor Code Section 4610(g)(7) allows the defendant to defer UR until a final decision on compensability, once compensability is determined, subsection (g)(8) requires the defendant to "begin UR of **retrospective treatment** 'on the date the determination of the employer's liability becomes final' and to initiate UR for **prospective treatment** recommendations 'from the date of the employer's receipt of a treatment recommendation after the determination of the employer's liability.'"

Applying this statutory framework to the disputed UR determination, the WCAB in *Belling* found that compensability was determined and then upheld by the Board as of June 21, 2013. The defendant did not initiate UR until six months later on January 21, 2014. The UR "was well beyond the permissible time period in Section 4610 (g)(8) and therefore, defendant's UR denial that issued on 2/4/14 was untimely."

Although the defendant in *Belling* did not file a Petition for Writ of Review, it would seem reasonable that the time limits specified in Labor Code Section 4610(g)(8) regarding the employer's liability becoming final would not become effective until 45 days after the decision denying reconsideration issued.

The WCAB took the defendant to task by noting the multitude of identical requests for the services at issue made by the internal treater prior to the finding of compensability. The WCAB found that the defendant's passive reaction to these requests in the context of an incapacitated and dependant applicant were both inexcusable and troubling. The opinion stated that "certainly after receiving the final determination for its liability for applicant's injury claims, it was incumbent upon defendant to take prudent steps to ensure its compliance with its mandatory obligation under section 4600 and 4610(g). It did not do so."

BELLING v. UNITED PARCEL SERVICE CONT.

Communications Between Applicant's Spouse and PQME: Ex Parte?

The WCAB also addressed the issue of communication between the applicant's spouse and the panel QME. The applicant's spouse attended her husband's examination and provided the panel QME with her husband's injury history and current complaints. At the time of this communication as set forth in the existing medical record, the applicant's injuries were such that he was unable to talk due to severe expressive cognitive deficits.

In this context, the Board found that this communication on the part of the applicant's spouse was in line with assistance provided by an interpreter on behalf of an individual who is unable to communicate in English to the panel QME. In light of this, the Board held that this communication fell within the exception set forth in Labor Code Section 4062.3(i). According to the Board, like interpretative services, the spouse's assistance in this instance was simply transmissions of information on behalf of the applicant so as to constitute communications by the applicant.

Home Healthcare Services Versus Existing Spousal Care

Looking next at the issue of the reasonableness and necessity of the home health care services at issue, the Board noted that pursuant to Labor Code Section 4600(h), these services are included in the definition of medical treatment. However, the Board also noted that in order for these services to be provided by the employer, they must first be prescribed by a physician. Secondly, the services must be subject to either official fee schedule or Medicare schedule as covered in Labor Code Section 5307.1 or Labor Code Section 5307.8 if no such schedules apply.

Examining the first condition of Labor Code Section 4600(h), the Board found that the services were first prescribed by the internal treater in his initial report dated 7/22/10, and repeatedly requested through multiple successive reports all the way up to the disputed report of 1/3/14. The first condition was satisfied.

Moving to the second condition, the Board found that the reporting by the internal treater documented that the applicant was completely dependent on others for his survival. As such, the prescribed home healthcare services were for his safety and survival coming under Labor Code Section 5307. Those services were deemed reasonable and necessary.

Additionally, the Board noted that home healthcare-type services rendered in the context of an existing marital relationship does not absolve the defendant from its

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up to $10,000 depending on the level of permanent disability. The voucher could be used for payment of tuition, fees, books, and other expenses required by qualified schools for retraining. The role of the QRR was very limited as compared to their past involvement as a rehabilitation plan was no longer required. There was initially no expiration date to use the voucher, but this was later amended. An employer could avoid payment of the voucher if it made a written offer to the injured worker of a modified work position meeting certain qualifications. Most helpful, the voucher could be settled.

Following the enactment of Senate Bill No. 863 we reach the current system governing injuries occurring on or after January 1, 2013. An injured worker who is not given a qualifying return to work offer, and meets certain eligibility requirements, is entitled to an SJDB voucher valued at $6,000 regardless of the level of the permanent disability awarded. Labor Code Section 4658.7(e), details how the voucher can be applied to various expenses, including a $1,000 computer equipment allowance and up to $500 for mileage expenses without any itemized accounting or documentation. If we consider that up to 10% of the current voucher value may be needed/used for placement services (return-to-work counseling, QRR etc.) together with the computer and mileage expenses allowed, then only $3,900 is left to provide for training, tuition, fees, licensing, etc. This is a significant reduction in comparison to the origin of the benefit.

Three big changes provided by Senate Bill No. 863 as compared to the prior systems are:

1. The voucher has an express expiration date (2 years from issuance or 5 years from the DOI, whichever is later);
2. Settlement or commutation of the voucher is **not** permitted; and,
3. Injuries sustained while using the voucher are by statute not compensable. (See, Labor Code Section 4658.7(f)-(i).)

From the claims viewpoint, the two year expiration has an accounting benefit by placing a time frame on the potential liability. This is a very practical consideration given there were a significant number of the earlier vouchers that were not used leaving liability open. Possibly the time limitation was a concession for the provision eliminating the ability to settle the voucher, or maybe the time limitation was intended to encourage an injured worker to use the voucher. Legislative history is not clear. Lastly, this recent codification of eliminating liability for injuries that may occur during the use of the voucher simplified settlement negotiations.

The Impact of the *Benson* and *Silva* Cases

The interaction of a few recent cases plays a significant role in the application and use of the voucher. In *Benson v. WCAB* (2009) 74 Cal.Comp.Cases 113, the court held that the doctrine of *Wilkinson v. WCAB* (1977) 19 Cal.3d 491 was inconsistent with the apportionment reforms enacted by Senate Bill No. 899. When the *Wilkinson* case was in force, applicant's counsel would look to join multiple injuries in one permanent and stationary date to cumulate permanent disability ("PD") into one much larger PD award. By comparison, the new apportionment is based instead on causation. Labor Code Sections 4663 and 4664 require each distinct industrial injury be separately compensated based on its individual contribution to the PD. This opportunity encourages a defendant, in most instances, to desire multiple injuries to reduce the PD value which is exactly the opposite strategy that previously existed under *Wilkinson*. This effect of *Benson* is not only to reduce the dollar value of the overall PD, but later paves the path that increased the number of vouchers an injured worker may be entitled to receive as we later will see under the *Silva* case.

The impact of the *Benson* apportionment is shown in three ways. First, non-industrially caused permanent disability is removed from consideration. Second, if multiple injuries cause permanent disability, the sum of the permanent disability caused from multiple injuries is almost always less than the sum of the permanent disability if it were only one injury. Consider the following examples for an injury occurring in 2014 assuming maximum rates:

> **Example A**: One injury causing 50% permanent disability results in an Award of **$78,662.50**
>
> **Example B**: Two injuries causing 25% permanent disability each result in an Award of $29,217.50 * 2 = **$58,435** which is $20,227.50 less than Example A.

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> **Example C**: Two injuries causing 50% permanent disability in total, i.e. 49% plus 1% = $61,410 ($76,560 + $870 = **$77,430**), which is $1,232.50 less than Example A.

A great reduction in claim value occurs when the PD for multiple injuries is rather equal, such as Example B, and least when the PD is most unequal such as Example C.

Further and probably most important, *Benson* apportionment can significantly reduce the PD value and avoid a life pension payment by splitting up the PD:

> **Example D**: One injury causing 70% PD results in an Award of **$125,642.50** plus a life pension of $77.31 per week.
>
> **Example E**: Two injuries causing 70% overall PD, split 69% ($122,742.50) plus 1% ($870) results in an Award of **$123,612.50**, which compared to Example D is $2,039 less for the indemnity and eliminates the weekly life pension payment as well.
>
> **Example F**: Two injuries causing 35% PD each result in an Award of $48,140 * 2 = **$96,280** which is $29,362.50 less than Example D plus it eliminates the $77.31 weekly life pension payment.

The strategy for defendants to maximize the impact of the *Benson* is to increase the number of injury events, to require the medical legal evaluator to apportion to each either Labor Code Sections 4663 or 4664. The goal of the defense strategy is to reduce overall dollar value. The applicant's strategy generally is just the opposite, however now we have a new twist.

The latest impact to affect the SJDB Voucher comes from the Noteworthy Panel Decision, *Ruben Silva v. LSG Sky Chefs; Liberty Mutual Insurance Company*, 2015 Cal. Wrk. Comp. P.D. Lexis 405. In short, Labor Code Section 4658.5 can be interpreted to entitle an applicant to a separate voucher for each date of injury! It does not appear that an appeal of the WCAB decision has been taken. As a Noteworthy Panel Decision the case is not binding on future litigation but it certainly has the prospect to upset negotiations and may be yet upheld in future cases. The potential impact on litigation is most felt in lesser PD cases as the savings from *Benson* apportionment may be overshadowed by the multiplicity of vouchers that need to be awarded. For instance, compare the hypothetical 50% PD injuries in Example B or C above. The additional cost of another $6,000 voucher eliminates most of the savings in Example C only.

By comparison, if the PD in the example was only an overall 20%: 20% PD = $21,895 versus two at 10% PD, $17,545 ($8,772.50 x 2 = $17,545), the overall savings in PD value by having two injuries versus one is only $4,350 ($21,895 - $17,545). The cost of the second *Benson* injury by reason of the additional voucher theoretically costs the defendants an extra $1,650 ($6,000 - $4,350 = $1,650).

The defendant's loss is even greater if the two injuries are very unequal such as 19% and 1% ($20,445 + $870 = $21,315) which otherwise would have a savings of only $580 in PD value ($21,895 - $21,315 = $580). Now, the second voucher increases the defendant's hypothetical loss to $5,420 ($6,000 - $580 = $5,420).

Although the *Silva* case is just a Noteworthy Panel Decision, further litigation may be an uphill battle. Under the facts of *Silva*, there were two dates of injury, a specific injury of April 16, 2010 (25% permanent disability) and a cumulative trauma injury from April 26, 2009 through April 16, 2010 (30% permanent disability). The body parts were overlapping, with each case having three identical body parts and cumulative trauma injury case having an extra body part. The periods of temporary disability for both injuries were concurrent. The holding of the case is a strict interpretation of the statute finding it clearly provides a voucher to each qualifying date of injury.

With the application of the *Silva* case, an injured worker potentially has as many vouchers as injuries, hence "the more injuries the merrier"! While the impact is likely greatest in smaller PD cases, in most cases *Silva* will probably not cause a significant change in the litigation strategy favoring multiple dates of injury. Medical evaluators will still need to determine the number of injuries to the legal standard of "reasonable medical probability" regardless of whether it is advocated by the defendant or applicant. The only difference post *Silva* is that counsel for applicant may advocate for a "poison pill" when the defendant first successfully raises *Benson*. Applicant

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will argue for as many injuries as possible to erode the defendant's savings. Since the applicant's best strategy for multiple vouchers involves smaller PD cases, this battle will probably be most often fought on the claims examiner's desk with repeated threats by applicant's counsel that he or she will litigate for multiple vouchers.

Thomas v. Sport Chalet Lives Even for the New Voucher

Labor Code Section 4658.7(g) states: "Settlement or commutation of a claim for the supplemental job displacement benefit shall not be permitted ...". This is similar to Labor Code Section 5100.6 which was in effect when the *Thomas* decision was decided in 1977. It states: "Notwithstanding the provisions of Section 5100, the Appeals Board shall not permit the commutation or settlement of compensation indemnity payments or other benefit to while the employee is entitled under rehabilitation." Thus, the *Thomas* Court held an applicant may settle his right to mandatory rehabilitation benefits for a lump sum, however only where there is a serious and good faith issue which has the potential to totally bar the worker's recovery of compensation benefits. There is nothing within Labor Code Section 4658.7 that contradicts the *Thomas* holding and so voucher settlements will likely continue to be approved if a good faith issue as to AOE/COE is demonstrated.

Will Any of the Above Impact Later "Superfund" Litigation?

There are additional ways in which an applicant may increase his benefit recovery after a work injury occurring on or after January 1, 2013. Senate Bill No. 863 created a "Superfund" which is codified within Labor Code section 139.48. It is also identified as the Return-to-Work Supplement Program (RTWSP). It is a separate benefit that does not affect the injured worker's ability to collect other compensation benefits. It states:

> (a) There is in the department a return-to-work program administered by the director, funded by one hundred twenty million dollars ($120,000,000) annually derived from non-General Funds of the Workers' Compensation Administration Revolving Fund, for the purpose of making supplemental payments to workers whose permanent disability benefits are disproportionately low in comparison to their earnings loss. Moneys shall remain available for use by the return-to-work program without respect to the fiscal year.
>
> (b) Eligibility for payments and the amount of payments shall be determined by regulations adopted by the director, based on findings from studies conducted by the director in consultation with the Commission on Health and Safety and Workers' Compensation. Determinations of the director shall be subject to review at the trial level of the appeals board upon the same grounds as prescribed for petitions for reconsideration.
>
> (c) This section shall apply only to injuries sustained on or after January 1, 2013.

Currently, if awarded, it is a one-time $5,000 Return-to-Work supplement.

According to the Department of Industrial Relations (DIR) website:

> As of June 30, 2015, DIR has made supplemental payments totaling $2,170,000 to injured workers. DIR had received 508 applications for the one-time payment of $5,000, of which DIR had completed reviews of 454, and the remaining 54 applications were in the review process. Of the applications reviewed, 388 applications were deemed eligible, and 66 were denied, either because the person was injured before Jan. 1, 2013, or the application was incomplete or a duplicate.
>
> Statistically then, 85% of the time the application is granted. (388/454=85.5%) The percentage is obviously higher though if one considers the reasons given for the 66 denials. There were no statistics provided which demonstrated that there were any denials because the required standard of showing the permanent disability benefits awarded were "disproportionately low in comparison to their earnings loss."

In the long term, it is reasonable to believe that the maximum supplemental payment sum will eventually increase above the current $5,000. If the basis for eligibility is to prove that permanent disability benefits are disproportionately low in comparison to earnings, is it not logical to think that proportionality will play a role in determining the sum of the payment? Will there eventually be a need for expert testimony concerning earnings loss? Will litigation over this issue overlap or conflict with *LeBoeuf* and *Almaraz/Guzman* arguments? If there is any objection to the award of the supplement, it is clear that the WCAB has jurisdiction and that procedure to be followed to object mirrors that of a petition for reconsideration, namely, that the objection be filed within 25 days after service of the award via U.S. Mail.

In consideration of the infancy of this program, litigation will probably shape the application of future benefits as will any "findings from studies" identified within Labor Code Section 139.48. The question in regards to whether entitlement to those Superfund payments will be litigated is difficult to answer at this point. It appears that the claims adjuster handling the underlying matter has no input on whether or not the Superfund payment is issued. Under Labor Code section 139.48 those payments are "... subject to review at the trial level of the appeals board upon the same grounds as prescribed for petitions for reconsideration" but who is charged with the duty to see that such a review is obtained?

Would that claims adjuster even have standing to object if the payment is not coming from the actual claim file? If the payment does not come from the claim file, what interest is served for the underlying claim to incur the expense to refute an injured worker's entitlement to the payment?

Last, is an injured worker entitled to two or more "Superfund" payments under the reasoning of the *Silva* case? At this time, there are more questions than answers. This area is in its infancy and litigation will most likely be necessary to finalize the approved use of the Superfund.

Conclusion

So we have come a long way from the unlimited rehabilitation plans of old, to a new system of $6,000 vouchers.

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UPCOMING CONFERENCES

2016 PARMA Annual Conference
Public Agency Risk Managers Association
February 23-26, 2016
Renaissance Indian Wells Resort & Spa
Visit the PARMA website for further details: http://parma.com/
*LFLM is exhibiting at **Booth #602**. Come by and pick up the **LFLM 2016 Public Agency Guidebook**.*

2016 RIMS Annual Conference
Risk Management Society
April 10-15, 2016
San Diego, California
***Susan Hastings** (LFLM Oakland) is presenting at the conference.*
"Deal or No Deal: Strategies for Effective Management of Public Safety Officer Clams" - April 12

2016 CWCDAA Annual Summer Conference
California Workers' Compensation Defense Attorney's Association
May 19-22, 2016
The Ritz-Carlton, Lake Tahoe

SAVE THE DATE!
2016 CAJPA Annual Fall Conference & Training Seminar
California Association of Joint Powers Authorities
September 13-16, 2016
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PANEL QME PROCESS

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Since the regulations now specifically provide for "service" of the panel list, the additional 5 days for mailing applies to the QME striking process.

REQUIRED DOCUMENTATION

In light of the new Online Panel QME Request system, and pursuant to the new regulations effective as of October 1, 2015, the parties are required to upload the following documentation in support of their request.

Compensability Dispute - Labor Code Section 4060

Pursuant to 8 Cal. Code of Regs Section 30(b)(1)(B), when requesting a panel QME list to address compensability, the parties can submit the following:

1. A copy of the claims denial notice or a copy of the delay notice.

If requesting a panel QME list within the initial 90 day period under Section 30(d)(1), until there is further clarification from the Medical Unit or Appeals Board, the following should be submitted:

1. The claim form (DWC-1)
2. Any claim delay notice(s) and acknowledgment of the filing of the claim requisite enclosures.

Permanent Disability – Labor Code Section 4061 and Other Medical Determination Dispute – Labor Code Section 4062

Pursuant to 8 Cal. Code of Regs Section 30(b)(1)(B), when requesting a panel QME list under Sections 4061 and 4062, a written objection letter to applicant's attorney indicating the following is required:

1. The identity of the treating physician;
2. The date of the treating report that is being objected to;
3. A description of the medical determination that requires a medical-legal report.

REQUESTS FOR PANEL QME LISTS IN THE APPROPRIATE SPECIALTY

The Board has recently changed the requirements for resolving disputes over the appropriate specialty of the panel QME list.

Title 8 Cal. Code Regs. Section 31.1(b) previously provided that when requesting a panel QME list in a specialty other than the specialty of the treating physician, the party needed to submit any relevant supporting documentation with their panel request form.

Section 31.1(b) was amended in August 2015 and now provides that disputes regarding the appropriateness of the specialty of the panel QME list, are to be resolved by the Medical Director pursuant to Section 31.5(a)(10). If either party disagrees with the determination made by the Medical Director, they can appeal it to a Workers' Compensation Judge.

Therefore, under Section 31.5(a)(10), to resolve a dispute over the correct panel QME list specialty, the parties must first write to the Medical Director requesting a review of the specialty of the panel QME. The requesting party must include the following with their request:

1. A copy of the Doctor's First Report of Occupational Injury;
2. A copy of the most recent PR-2 or narrative report; and
3. Any additional information requested by the Medical Director to make a determination.

If the parties disagree with the Medical Director's decision, they may file for an evidentiary hearing on the issue at the Workers Compensation Appeals Board.

At the hearing, consideration will be made for the following:

* Objection and timeliness of objection to the specialty of the panel QME list. [*Natividad v. Sherbourne Properties, Inc.* (2015) Cal. Wrk. Comp. P.D. Lexis 305 (not a significant panel decision), the Appeals Board ruled in favor of applicant's attorneys despite their defective panel request in the wrong specialty, because defendant's request was issued over four months after the panel request was made.]

* Evidence that either party expressed a preference for a QME panel list in a specialty other than the specialty of the primary treating physician. (*Lagunas v. Mi Pueblo,* (2014) Cal. Wrk. Comp. P.D. LEXIS the Board noted that the applicant had not requested a panel list in any specific specialty nor had they expressed to defendant their wish to have the panel QME be a different specialty than that of the primary treating physician.)

* Consideration of whether the injury in question was an admitted or denied claim and the nature of the injury, i.e. orthopedic, neurologic, psychological, etc. *(Lagunas v. Mi Pueblo,* (2014) Cal. Wrk. Comp. P.D. LEXIS the WCJ considered that the claim involved an admitted low back injury and claimed shoulder injury, both of which are musculoskeletal injuries best addressed by an orthopedic physician.)

The Appeals Board has not always agreed that an evidentiary hearing is necessary. In *Richmond v. Santa Rosa Tile, Inc.* (2014) Cal. Wrk. Comp. P.D. LEXIS 658, the Board in a split decision held that under Section 4062.2 there was no requirement that the specialty of the panel be the same as the treating physician. They therefore allowed applicant's attorney's request for a pain management panel to stand without referring it back down to the trial level for an evidentiary hearing.

In the dissenting opinion, Commissioner Zalewski noted that the matter should have been returned to the trial level for an evidentiary hearing on the issue of the appropriate QME specialty because applicant's attorney did not provide support for their request in a different specialty.

The Workers' Compensation Newsletter is published by Laughlin, Falbo, Levy & Moresi LLP. Contributors to this issue include Nicholas Pavlovich (Redding), Julio Salazar (Pasadena) and Alicia Valencia (Santa Monica).

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REQUESTS FOR MULTIPLE PANELS BY MULTIPLE CARRIERS

In the recent panel decision of *Chanchavac v. LB Industries, Inc.*, 2015 Cal. Wrk. Comp. P.D. LEXIS 516, the Appeals Board found that co-defendant Sentry Insurance was entitled to their own panel QME in orthopedics to address the applicant's cumulative trauma injury even though the applicant and co-defendant Twin City Fire Insurance, had already obtained a separate panel QME list and QME report in chiropractic medicine.

The applicant's attorney objected on grounds that 1) there was only one employer in the case and therefore there should only be one panel; 2) there was privity among the carriers entitling them to only one panel; 3) the specialty of the treating physician was chiropractic not orthopedics; and 4) multiple panel QME reports would complicate the case.

The Board rejected all of the applicant's arguments and adopted the WCJ's report and recommendation.

The WCJ found that while the applicant's attorneys had a good point in that multiple reports would complicate proceedings, that issue could have been remedied had they elected against one defendant. That was the whole purpose of Labor Code Section 5500.5; election to avoid complicated proceedings.

The WCJ noted that "[i]f [applicant] does not wish to designate one carrier with whom she wishes to litigate, she must litigate with all of them, all of whom must in turn be permitted to defend their own interests as they see fit."

While the above decision is rational and came to the appropriate conclusion, as one author discussing the *Chanchavac* case previously noted, it leads to the question of whether an applicant's attorney can now hold off on electing against multiple carriers, allowing them to obtain their own panel QME lists and reports, and electing against the defendant with the most favorable report to the applicant.

Notwithstanding the above, the opinion definitely highlights an opportunity for carriers who, for example, were just joined on a case involving a chiropractic PQME who

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VOUCHERS

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The strategy employed by defendants to reduce permanent disability by reason of *Benson* is potentially now countered by the *Silva* rule to increase the number of vouchers available, especially in lower PD cases. The battle between *Benson* PD savings through apportionment, and the threat of multiple vouchers under *Silva*, is likely to be played out on the claims examiner's desk where the cost of defense counsel is harder to justify. Examiners will argue for multiple injuries to save under *Benson* whereas applicant's attorney will counter with threats of multiple vouchers. Regardless, while the new voucher cannot be settled, except by a *Thomas* finding, defendants will enjoy the two-year expiration date.

While multiple vouchers may be the *Silva* rule, it remains to be seen whether it will result in multiple $5,000 payments from the "Superfund," or whether the Legislature really meant to only consider those injured workers whose permanent disability is "disproportionately low" in comparison to their earnings loss. Absent clarifying legislation or new studies concerning earnings loss set forth in section 139.48, only costly litigation will continue to shape the new approach to rehabilitation for the injured worker. ◆

BELLING v. UNITED PARCEL SERVICE

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obligation to provide those services. Although Labor Code Section 5307.8 states that, "[f]ees for home healthcare shall **not** be provided for any services, including any services provided by a member of the employee's household, to the extent the services had been regularly performed in the same manner and to the same degree prior to the date of the injury", the WCAB pointed out that "[a]n employer or insurance carrier . . . is not a third party beneficiary to a marriage contract and is without right to assume or contend that the spouse of an injured employee . . . is under any obligation to exert added physical efforts to attend to the injured spouse's needs which otherwise would be the responsibility of the employer to furnish." *Belling* at page 13, quoting from *American Bridge Division, U.S. Steel Corp v. Ind. Acc. Com* (1965) 30 CCC 159 (writ denied). On the contrary, as commented on by the Board, taking advantage of such a relationship by failing to act on such services as requested can lead to other repercussions such as referral to the Audit Unit.

What Does All This Mean?

This case addressed multiple issues that frequently arise in today's litigation. Probably the most pertinent one right now, given the frequent disputes over UR decisions, is the holding regarding retrospective UR on previously denied compensable cases. Under *Belling*, it is incumbent upon attorneys and adjusters alike to make sure that once a claim is deemed compensable, UR is timely instituted on a **retrospective** basis on previously requested medical treatment on newly compensable cases.

And remember, just because the non-injured spouse is the primary caretaker of the home, that does not preclude the obligation to provide outside home healthcare services once prescribed and certified by UR on a compensable case. That spouse can actually help a case run more smoothly by providing "translation" for an incapacitated applicant when necessary. Of course, defendants must remain vigilant in confirming that such translations or communications are supported by the medical record.

Applicant's attorneys are often fond of saying workers' compensation is a system of furnishing benefits, while defendants contend their role is to ensure the provision is appropriate, reasonable and necessary. Both are correct, but *Belling* clearly indicates the proactive role the WCAB believes defendants should take. ◆

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already reported but without a formal election. The applicant can then expect to deal with not only multiple QME's but multiple QME's in different specialties.

This concludes our journey through the panel QME process. It is one of the many constantly changing labyrinths we navigate in the workers' compensation world. As is the case with most mazes, there are multiple strategies to get around and emerge from them. The guidelines above provide some effective strategies to get through the panel labyrinth; or at the very least, make navigating it a little smoother…that is, until it all changes again... ◆

FIRM ANNOUNCEMENTS

New Partners

We are pleased to announce that effective 1/1/15, two LFLM attorneys are joining the ranks of partnership:

Omar Behnawa of our San Diego office, practicing California workers' compensation defense.
Maryam Jalali of our Anaheim office, practicing California workers' compensation defense.

Congratulations Omar and Maryam!

Alfonso J. Moresi Retires – Once and For All!

One of the Firm's richest sources of entertainment and legal expertise retired. Alfonso J. Moresi left the building for the last time on 12/31/15.

Al began his career as a defense attorney in California Workers' Compensation at the law firm of Sedgwick, Detert, Moran & Arnold. After seven years, he joined forces with his fellow upstarts and founded Laughlin, Falbo, Levy & Moresi LLP in 1985.

During the following 22 years, Al built and solidified his reputation as a sharp legal mind in workers' compensation. His quick wit and open demeanor made him a favorite among attorneys and judges alike. Al's easy manner and depth of knowledge earned the respect of the community as he frequently gave presentations and seminars for the benefit of the industry and attorney groups.

In 2007, Al retired from the Firm to join the WCAB as a Commissioner appointed by Governor Arnold Schwarzenegger. During his seven-year term, Al was again a frequent presenter, this time on behalf of the WCAB traveling up and down California educating the workers' compensation community at large on the inner workings of the WCAB.

But when his term ended, he decided that full retirement was not for him. He missed litigation. In 2014, he came out of "retirement" and returned to the Firm. It took Al another two years to realize that retirement really is more fun.

The Firm is a better place for his presence and knowledge. We will miss him.

Enjoy retirement, Al! It's about time!

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