

**CALIFORNIA WORKERS' COMPENSATION  
DEFENSE ATTORNEYS ASSOCIATION**

**JUNE 2009 CONFERENCE**

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

**FEBRUARY 2008 - MAY 2009**

Presented by

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June 2009

Pamela Foust  
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## **DISCLAIMER**

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

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

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**Summary of  
Recent Significant Decisions in  
California Workers' Compensation Law  
February 2008 – May 2009**

**I. Jurisdiction and Venue**

**II. Employment**

**III. Insurance Coverage/California Insurance Guarantee Association**

*California Insurance Guarantee Association v. WCAB (Thomas)* (2008) 73  
CCC 1519, Court of Appeal, Second Appellate District, Division Five.

Applicant sustained an industrial injury while employed by a company that supplied workers to contractors. The contractor to whom applicant's labor was supplied was insured by the State Compensation Insurance Fund. The labor supply company that employed applicant was insured by an insurance carrier that went into liquidation. Thus, CIGA was joined.

The matter proceeded to trial to resolve a dispute concerning the application of Labor Code §§1063.1(c)(9) which provides, in part, "Covered claims' does not include (A) any claim to the extent it is covered by any other insurance of a class covered by this article available to the claimant or insured . . . ." The parties stipulated that the supplier was the general employer and the contractor was "one of the special employers." The specific questions to be answered were 1) whether the SCIF policy was "other insurance and 2) whether applicant was not covered under §§1063.1(c)(9). Additionally, SCIF moved for dismissal on the basis that under the facts of this case, its insured contractor was the general employer and CIGA was the "other coverage."

The WCJ found CIGA liable and awarded applicant PD and future medical care, ruling that without the actual SCIF policy being in the record, there was no evidence of "other insurance" covering special employees like applicant under §1063.1(c)(9).

CIGA petitioned for reconsideration and the WCAB denied the petition. The Board agreed with the WCJ's decision that there was no evidentiary basis to find that the SCIF policy was "other insurance" under section 1063.1(c)(9). According to the Board's rationale, CIGA had to meet its burden of proof by placing the SCIF policy into evidence and showing actual coverage and no form endorsement excluding special employees. At that point, the burden would have shifted to SCIF to show that coverage was otherwise excluded.

CIGA petitioned for a writ of review, contending that the existence of the SCIF policy was established at trial by the WCIRB letter and SCIF's admission to insuring the contractor. The Court denied judicial review. CIGA then petitioned for review in the Supreme Court. The Supreme Court granted review and ordered the Court of Appeal to vacate the order denying review and to issue a writ of review.

The Court disagreed with the WCAB that CIGA was required to produce the SCIF policy at trial to establish that "other insurance" covered SCIF's insured and that there was no form endorsement excluding special employees, finding that the relevant terms of an insurance policy may be established by secondary evidence such as discovery responses or admissions. It agreed with the WCAB that the WCIRB letter was not substantial evidence of other coverage.

However, the Court found to be relevant the fact that SCIF's attorney stipulated at trial that his client insured the contractor as one of the special employers of applicant. A concession by counsel at trial eliminates the need to prove the fact or issue admitted and is binding on the client absent fraud. Thus, CIGA was not required to produce the SCIF policy to show that special employees were covered or that coverage was not excluded.

Moreover, SCIF's counsel moved for dismissal at trial based on *Miceli*, a line of cases in which there was no form endorsement excluding special employees. As a result, there was an implied judicial admission at trial by counsel for SCIF that the SCIF policy did not contain the form endorsement excluding special employees.

The Court found that as applicant's general and special employer, both CIGA and SCIF were jointly and severally liable to applicant for work injury due to the dual employment. Therefore, the SCIF policy provided "other insurance" under §1063.1(c)(9). SCIF was liable for coverage of applicant's injuries, not CIGA. The WCAB's decision that CIGA was liable was reversed, and the matter was remanded for further proceedings consistent with the Court's opinion.

#### **IV. Injury AOE/COE**

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

Applicant was employed as police officer assigned to the SWAT team. He was required to pass an annual physical fitness test. The employer paid him to train four days each month and had sent him to train out of state. He maintained his physical fitness by running, bicycle riding, and weight lifting with other SWAT team members outside of work for which he was not paid. He normally ran while on vacation to maintain his fitness.

In preparation for his annual test in January 2006, applicant began a course of fitness training that he expected to continue during a two week vacation. On December 30, 2005, while on vacation in Wyoming, he went for a three-mile run, slipped, and broke his left

ankle. He was unable to take the January 2006 physical fitness exam, but took and passed a subsequent test.

Defendant denied applicant's workers' compensation claim, claiming that his injury occurred while he was voluntarily participating in an off-duty recreational or athletic activity. The WCJ agreed with defendant finding that applicant's belief that the employer expected him to jog during his vacation was not objectively reasonable. Applicant petitioned for reconsideration and the WCJ commented in his report that, if one accepted applicant's position that his injury was work related, "then every SWAT Officer in this State is covered for Workers' Compensation 24 hours a day, any place in the world." The WCAB adopted the WCJ's report and denied reconsideration. Applicant filed a petition for writ of review, which was granted.

The Court of Appeal noted that Labor Code §3600 excludes injuries arising out of voluntary participation in off-duty recreational, social, or athletic activities unless those activities are a reasonable expectancy of the employment. Per *Ezzy v. WCAB* (1983) 48 CCC 611, the reasonable expectancy test consists of two elements: (1) whether the employee subjectively believes his or her participation in an activity is expected by the employer, and (2) whether that belief is objectively reasonable. Since applicant's testimony that he believed he was expected to train was un rebutted, only the second element of the *Ezzy* test was at issue.

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

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

In a strongly worded dissent, one justice agreed with the WCJ who believed there was no legislative intent to cover an employee at all times, no matter where the employee was located.

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

*A. Teichert & Son, Inc. v. WCAB* (2008) Barron) 73 CCC 1621, Court of Appeal, Third Appellate District, unpublished opinion.

Applicant's husband suffered a ruptured aneurysm in the course of his employment that caused his death. On the same morning, he was involved in a heated argument with his supervisor. The widow obtained a report from a QME who expressed the following opinion regarding medical causation.

“[I]t is medically possible [he] may have become angered at his supervisor and that this anger may have been translated into increased blood pressure, with the increased blood pressure then leading to the rupture of a presumed aneurysm, which has not been documented. However, there is no way one can say with reasonable medical probability that this chain of events actually occurred and was causative of his death. All we can say is that this is one possible scenario, which cannot be proven or disproved.”

The matter came on for trial on the sole issue of whether the QME's opinion established industrial causation of the ruptured aneurysm. The WCJ found that it did, stating that a causal connection does not have to be proved in detail and it was therefore not necessary to know what the employee's blood pressure was at the time of rupture. He felt that the QME's report was “more persuasive” in showing a causal connection than not. Defendant petitioned for reconsideration and the WCAB adopted the WCJ's decision. Defendant then sought judicial review.

The Court of Appeal first noted that while it was clear that the death occurred in the course of employment, there was no substantial evidence that it arose out of the employment. As a general rule, the fact that an employee becomes disabled from the natural progression of a nonindustrial disease during employment will not establish the causal connection. There are two general exceptions to this rule: 1) if the employment subjects the employee to an increased risk compared to that of the general public, and 2) if the immediate cause of the injury is an intervening human agency or instrumentality of the employment.

The applicant apparently relied on the second exception. Thus, she had to prove by a preponderance of the evidence that it was reasonably probable that the argument with his supervisor caused her husband's blood pressure to suddenly increase enough to rupture his aneurysm. The QME stated that an aneurysm could burst at any time and he could not say with reasonable medical probability that the blood pressure rose due to the argument and burst the aneurysm. The doctor did not state that anger usually raises a person's blood pressure, only that it can do so. The Court therefore found it speculative to assume that simply because an argument can raise a person's blood pressure, it probably did so in this case and probably spiked enough to burst the aneurysm. Therefore, the Court annulled the Board's decision.

**B. Presumptions**

*Fain v. WCAB* (2008) 73 CCC 1543, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant, a police officer, developed a malignant brain tumor which he claimed was caused by “repeated stress and strain of employment and chemical exposure.” He subsequently passed away and his wife pursued his workers’ compensation claim.

The parties disputed the applicability of the cancer presumption for peace officers under Labor Code §3212.1 and utilized an AME whose report was offered into evidence as well as transcripts of the depositions of the deceased employee and two witnesses. The WCJ concluded that the presumption had not been established and that even if it had, defendant successfully rebutted it. Denying reconsideration, the WCAB agreed with the WCJ’s report and recommendation. Applicant then sought judicial review.

The Court first noted that “a presumption becomes operative at trial when the basic facts giving rise to the presumption are established by the pleadings, by stipulation, by judicial notice, or by evidence.” To invoke the §3212.1 presumption, the employee must prove that he or she “was exposed, while in the service of the department or unit, to a known carcinogen as defined by the International Agency for Research on Cancer, or as defined by the director.” The presumption may then be rebutted by evidence that 1) the primary site of the cancer has been established and 2) exposure to the recognized carcinogen is not reasonably linked to the disabling cancer.

Here, Petitioner never established the underlying basic facts necessary to invoke the presumption since no evidence was presented that her husband was ever exposed to a known carcinogen while working for defendant as a police officer. The AME could not find exposure to a known carcinogen. The witnesses testified to exposure to toxic chemicals, but not to known carcinogens. Moreover, there was no medical evidence otherwise suggesting a causal relationship between the employment and the brain tumor. Therefore, the petition for writ of review was denied.

**VI. Res Judicata/Collateral Estoppel****VII. Discovery****VIII. Earnings/Compensation Rate**

**IX. Temporary Disability**

*Foster v. WCAB* (2008) 73 CCC 466, Court of Appeal, Third Appellate District.

Applicant was injured at work in two separate incidents in February and April 2005. Both injuries contributed to his temporary disability. The WCJ concluded that applicant was entitled to two periods of TD indemnity under Labor Code §4656(c)(1) for his injuries. As to the first injury occurring in February 2005, the WCJ awarded him TD benefits from April 2005 until September 2006, when the first injury became permanent and stationary. As to the second injury, occurring in April 2005, TD was awarded commencing in September 2006. The WCAB granted reconsideration of the WCJ's award. The Board agreed that applicant was entitled to two periods of TD, but concluded that where independent injuries result in concurrent periods of TD, the 104 week/2 year limitation likewise runs concurrently. The Court of Appeal issued a writ of review to consider this issue of first impression.

Both the WCJ and the WCAB determined that applicant became unable to work on the same date as a result of the combined effects of both injuries. He was entitled to only one amount to substitute for his lost wages. The Court found nothing in the language of §4656(c)(1) to suggest that the limitations period for a single injury causing TD should be tolled for any period during which a worker is entitled to TD benefits based on another injury. Nor was there language in the statute suggesting that the limitations period would not run concurrently where multiple injuries caused an overlap, either partial or complete, during periods of TD.

If the Court were to accept the interpretation of the WCJ, the employer's responsibility for TD indemnity could be extended unpredictably for an undefined number of payments and years in situations where multiple independent injuries result in staggered or overlapping periods of TD. The Court did not believe such a consequence was intended by the Legislature. Therefore, it affirmed the Board's decision after reconsideration.

*Brooks v. WCAB* (2008) 73 CCC 477, Court of Appeal, Fifth Appellate District.

Applicant, a state employee was paid one year of Industrial Disability Leave (IDL) and thereafter TD. After one year of TD, defendant terminated her benefits citing the two-year cap on TD in Labor Code §4656. Applicant contended she was entitled to another year of TD because the two-year limitation did not begin running until after her initial year of IDL payments ceased. The WCJ disagreed, reasoning that IDL is the functional equivalent of TD and that the new statutory limit authorized only 104 weeks of combined IDL and TD indemnity. The WCAB denied reconsideration, adopting the report and recommendation of the WCJ.

The Court first discussed the differences between IDL and TD. It then pointed out that Government Code §19870(a) expressly provides that IDL "means temporary disability."

Because IDL is statutorily defined as the equivalent of TD, then the two-year limitation under Labor Code §4656(c)(1), necessarily must apply to both IDL and TD. Furthermore, the two-year limitation does not restrict itself only to TD benefits payable under the Workers' Compensation Act or the Labor Code, as it more broadly applies to "Aggregate disability payments for a single injury."

The Court rejected applicant's argument that the removal of the ability of state employees to choose between IDL and TD adopted by a 1994 amendment demonstrates that the benefits carry different purposes and that TD begins only after the IDL "salary continuation benefit" is exhausted. CAAA had argued in its amicus brief that the WCAB's determination would negatively impact the abilities of injured state employees to care for their families and that, "Rather than placing the burden of compensation on the employer, said injured workers would be forced to look at various programs funded by the taxpayers for financial relief." However, the Court responded that "whether the state pays IDL, TD, unemployment insurance, or state disability insurance, the various programs are *all* funded by the taxpayers in the case of industrially injured state employees." Thus, the Court affirmed the decision of the WCAB.

*Mt. Diablo Unified School District v. WCAB (Rollick) (2008) 73 CCC 1212, Court of Appeal, First Appellate District, Division Four.*

Applicant, a special education assistant working for a school district, was injured in June 2004. She asserted a claim for workers' compensation benefits that the employer initially denied. In January 2007, the parties entered into a stipulation that provided for TD up to the date of the stipulation and continuing. In February 2007, the defendant filed a petition for an order terminating further liability for TD indemnity based on Labor Code §4656 (c)(1) which provides for termination of TD payments two years from the date payments commence.

Defendant had paid applicant benefits pursuant to Education Code §44043 which directs a school district to pay an injured employee receiving TD benefits his or her normal wage by supplementing the disability benefits with the employee's accrued leave time. The dispute came on for trial. The WCJ found that Education Code Benefits do not constitute TD payments, presumably meaning that applicant's TD benefits did not commence, for purposes of §4656 (c)(1), when defendant made the first payment of Education Code benefits.

Defendant filed a petition for reconsideration. In an opinion and order denying the petition, the WCAB agreed with the WCJ and further stated:

"In summary, we will deny the School District's petition for reconsideration because the plain language of Education Code section 44043 is language that restricts the total amount an employee can receive from both temporary disability and other 'Education Code benefits.' It is not language that equates temporary disability to such other benefits for purposes of the limitation[s] of Labor Code section 4656(c)(1)."

Defendant then filed a petition for writ of review.

The Court noted that entitlement to Education Code §44043 benefits is contingent on payment of workers' compensation TD benefits. The procedure outlined in the statute is for the employee to endorse and hand over the disability check to the school district which would pay the employee his or her normal wages as long as the employee had accrued leave available. The fact that the school district issues a single check combining TD and leave benefits does not change the essence of the underlying payments.

Defendant admitted that it does not precisely follow the statutory procedure. Rather, for the sake of convenience, its "insurer" issues a "voucher" equal to the injured worker's TD rate directly to the school district. Applicant argued that she was not receiving TD. Instead she "simply received full salary from the District," and that if defendant decided not to follow the statute, it cannot argue TD commenced with the first payment of §44043 benefits. The Court rejected this argument as an elevation of form over substance.

Finally, the Court addressed applicant's argument that §44043 payments are analogous to salary continuation benefits payable to public safety workers under Labor Code §4850 which the WCAB had declared are not subject to the two-year limit on payment of TD. Section 4850 provides for payment of salary "in lieu of temporary disability payments." Section 44043, rather than providing for payment in lieu of temporary disability, provides for payment of accumulated leave time in addition to TD payments. The Court concluded that Education Code §44043 provides a different and inferior benefit to that provided by Labor Code §4850. Thus, the Court annulled the Board's decision and remanded the care for further proceedings consistent with its opinion.

## **X. Medical Treatment**

### **A. In General**

*Facundo-Guerrero v. WCAB* (2008) 73 CCC 785, Court of Appeal, First Appellate District.

Applicant sustained an industrial injury for which he received 76 chiropractic treatments. The WCAB determined he was only entitled to 24 chiropractic treatments pursuant to Labor Code §4604.5(d). He filed a petition for writ of review, contending that §4604.5(d) violated the California Constitution's mandate for a "complete system of workers' compensation," (Cal. Const., art. XIV, § 4 (Section 4).) Additionally, he contended that vesting sole authority in employers to approve benefits for more than 24 treatments without affording workers a right of judicial review of that decision was an unconstitutional delegation of legislative power that violated his due process rights. Lastly, he argued that the limitation on the number of chiropractic treatments violated his right to equal protection under the law.

The Court of Appeal first sought to determine what was intended by the broad language in Section 4 of the California Constitution, and whether the proper interpretation of that provision supported petitioner's argument. The Court concluded that it was abundantly clear that as a matter of law, Section 4 neither restricts the Legislature's ability to limit the number of chiropractic treatments for which the workers' compensation system must be financially responsible, nor does it expand an injured worker's constitutional rights to include an entitlement to receive unlimited treatments. Therefore, the Court declined to second-guess the wisdom of the Legislature in meeting the workers' compensation crisis in this state by, among other things, specifying the maximum amount of chiropractic care an injured worker may receive for a single industrial accident.

The Court next addressed petitioner's complaint that the statutory exception allowing an employer to authorize chiropractic services in excess of 24 treatments constitutes an unconstitutional delegation of legislative power, or otherwise constitutes a deprivation of due process. It concluded that even if this could be read as requiring the Legislature to build a dispute adjudication or resolution procedure into the workers' compensation system, a disagreement with an employer's refusal to approve excess treatments does not give rise to a legally cognizable "dispute." Thus, the Court found nothing unconstitutional about Labor Code §4604.5(d).

Alternatively, petitioner claimed that §4604.5(d) violated his constitutional right to equal protection under the law on the ground that limiting the number of chiropractic treatments unlawfully treats his class of injured workers differently from the class of injured workers who undergo forms of treatment other than chiropractic care, as well as that his class of workers was being treated differently from those workers who were injured prior to January 1, 2004. However, the Court noted that applicant was not a member of a "suspect class," which is a foundational prerequisite for making such a constitutional claim.

The Court further stated that there was a rational basis for the statute which was declared to be urgency legislation, enacted to provide relief to the state from the effects of the current workers' compensation crisis at the earliest possible time. The Court found that the Legislature's decision to reduce the unlimited availability of chiropractic treatments to workers' compensation claimants was rationally related to that effort. Like its refusal to second-guess the Legislature's wisdom in enacting the 2004 amendments in consideration of petitioner's other constitutional arguments, the Court concluded that it must similarly refrain from doing so under the guise of an equal protection challenge. Thus, the Court upheld the WCAB's decision.

**B. ACOEM Guidelines/Utilization Review**

*State Compensation Insurance Fund v. WCAB (Sandhagen)/Sandhagen v. WCAB (2008) 73 CCC 981, Supreme Court.*

Applicant's consulting physicians requested an MRI to determine whether he had a herniated disc at the location of his pain. Twenty-eight days after the request for authorization was submitted to defendant, defendant's UR doctor denied the request as not being compliant with the ACOEM Guidelines. The dispute came on calendar for an expedited hearing. The WCJ found that the defendant had not complied with the Labor Code §4610 time deadlines and therefore, the UR report was not admissible into evidence. She also found the request for an MRI to be consistent with ACOEM. Defendant sought reconsideration.

The WCAB issued an en banc decision in which it affirmed the WCJ's findings concerning the inadmissibility of the late UR report. The Board also found if a defendant fails to meet a UR deadline, it may utilize the AME/QME procedures set forth under Labor Code §4062. However, any UR report that is not generated in compliance with the UR deadlines may not be provided to the AME or QME. Furthermore, there must be compliance with the statutory time periods in §4062(a), which allows 20 days for written objection in represented cases and 30 days where the injured worker is unrepresented. In this case, the Board found good cause to excuse the defendant's failure to object within 20 days, and remanded the case to the trial level to give defendant an opportunity to obtain a §4062(a) evaluation.

Both applicant and defendant filed petitions for writ of review with the Court of Appeal. Applicant claimed that since the UR process is mandatory, if a statutory time deadline is not met, the request for authorization is granted by default. Defendant argued that only monetary penalties can be imposed for its tardiness and that it has the right to pursue remedies under §4062(a). The WCAB contended that defendant was precluded from using its UR report to support the denial, but had the right under §4062(a) to support its denial of authorization with other evidence.

The Court of Appeal rejected defendant's argument that the WCAB exceeded its authority when it excluded the UR reports. It also rejected applicant's argument that the mandatory language of §4610 requires defendants to utilize the UR process for every treatment request. It found to be more persuasive the contentions of defendant and the WCAB that although employers are required to establish a UR process, they are not required to apply that process to every request for treatment.

The Court disagreed with applicant's contention that only the employee can invoke §4062 and that the option is not open to the employer. However, it agreed with the WCAB that if a defendant timely elects to follow the UR process, but does not fully authorize the proposed treatment after UR is completed, then any remaining disputes regarding the particular proposed treatment must be resolved using the procedure established by section 4062(a). Thus, both of the petitions for writ of review were denied.

Both applicant and defendant sought review in the Supreme Court which was granted. The Supreme Court identified the following issues:

- (1) When deciding whether to approve or deny an injured employee's request for medical treatment, must an employer conduct utilization review pursuant to Labor Code section 4610?
- (2) As an alternative to utilization review, may an employer elect to dispute a request for medical treatment under section 4062, which permits an employer to object to "a medical determination . . . concerning any medical issues . . . not subject to Section 4610 . . . .?"

Regarding the first issue, defendant contended that §4610 simply requires employers to "establish" a utilization review process, but does not require employers to actually use that process. The Supreme Court found this argument to be unpersuasive since the statutory language requires all employers to use the UR process in connection with any and all requests for medical treatment, and it was unlikely that the Legislature intended to allow employers to circumvent that process whenever they might find it to be expedient.

Defendant argued that if the employer decided to authorize the treatment without UR, imposing the UR process would be both time consuming and expensive. However, the Court pointed out that in such a scenario, the employer has actually engaged in UR. Thus, all employers are required to conduct utilization review in all cases in which authorization for medical treatment is requested.

Turning to the second issue, the Court noted that §4062 permits employers to object to a treating physician's medical determinations, but *only* to those determinations regarding "medical issues not covered by Section 4060 or 4061 *and not subject to Section 4610...*" On the other hand, the statute explicitly permits employees to use its provisions to object to an employer's "decision *made pursuant to Section 4610* to modify, delay, or deny a treatment recommendation..." Therefore, §4062 simultaneously *precludes* employers from using its provisions to object to employees' treatment requests but *permits* employees to use its provisions to object to employers' decisions regarding treatment requests.

In conclusion, the Supreme Court held that the Legislature intended to require employers to conduct utilization review when considering employees' requests for medical treatment and that they may not use §4062 as an alternative method for disputing employees' treatment requests. The judgment of the Court of Appeal was reversed and the matter remanded to that court for further proceedings consistent with the Supreme Court's opinion.

**XI. Medical Evidence****XII. Lien Claims and Costs****A. Lien Claims**

*Tapia v. Skill Master Staffing* (2008) 73 CCC 1338, Appeals Board en banc decision.

Lien claimant, an outpatient surgery center, billed \$23,529.00 for outpatient surgery center services it provided in connection with surgery performed at its facility in 2002. Defendant paid \$1,667.66, leaving a claimed balance of \$21,861.34. The matter came on for a lien trial and various exhibits were taken into the record. In lieu of the testimony of defendant's bill reviewer, the parties stipulated to the content of his testimony concerning DRG values of inpatient facilities in the geographic area, the allowance under the 2004 fee schedule, and The Medicare fee schedule for hospital based outpatient surgery centers. Neither party presented information regarding fees accepted by other outpatient surgery centers in the same geographic area as evidence of a reasonable fee.

The WCJ found the reasonable value to be \$4,700.00, "less credit for prior sums paid along with interest thereon." Lien claimant petitioned for reconsideration, contending that defendant did not present evidence of fees accepted for the same services by outpatient surgery centers in the same geographic area pursuant to the Board's en banc decision in *Kunz v. Patterson Floor Coverings, Inc.* (2002) 67 CC 1588, and that in the absence of such evidence from a defendant, *Kunz* requires that the full amount of an outpatient surgery center's lien be allowed as a reasonable fee.

The Board, sitting en banc, first noted that the essential question was whether the outpatient surgery center's lien was "reasonable." The lien claimant has the affirmative burden of proving that its lien is reasonable, and it must carry this burden by a preponderance of the evidence. It is not a defendant's burden to prove that the claimed fee is not reasonable. In determining the reasonable fee, the WCAB may take into consideration a number of factors including but not limited to, the provider's usual fee and the usual fee of other providers in the geographical area in which the services were rendered. While the billing itself may be evidence of what the lien claimant accepts, it does not establish that the claimed fee is "reasonable."

Rebuttal evidence may be presented on the question of the reasonableness of a lien claimant's billing, including but not limited to evidence that the lien claimant actually accepts less for the same or similar services; or that other outpatient or inpatient surgery centers in the same geographical area accept less for the same or similar services. In view of the phrase, "including but not limited to," a defendant or lien claimant may present *any* relevant evidence concerning the reasonable value of the services.

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Lien claimant cited *Universal Building Services v. Workers' Comp. Appeals Bd. (Yturbe)* (2006) 71 CCC 655 (writ denied) for the proposition that an outpatient surgery center's billing must be accepted as proof of a reasonable fee if a defendant does not present evidence of what other facilities "accept" for the same or similar services. The Board noted that although "writ denied" cases are citable authority as to the holding of the Appeals Board in its underlying decision, they may be overruled by the Board sitting en banc.

Here, the lien claimant only presented its billing as evidence whereas the defendant presented extensive rebuttal evidence, including stipulations as to what its bill reviewer would have testified. Even if defendant had presented *no* rebuttal evidence, the most that lien claimant's billing could establish is that this is the amount that it and other providers in the same area usually accept for the services rendered; not that the amount claimed is "reasonable." And even then, the amount billed would not have to be accepted if it was unreasonable on its face.

The stipulated testimony of defendant's bill reviewer established that the bill was over four times more than the legally allowable amount for inpatient hospitals in the same geographic area for the same services. Medicare would have allowed a fee that is approximately 95% less than what lien claimant billed. The current OMFS would allow \$1,770.34 in contrast to the billed amount of \$23,529.00. While the new fee schedule cannot establish what constitutes a "reasonable" fee for services provided before its effective date, it does provide some measure of reasonableness, when considered in light of the evidence presented.

The Board found that in the absence of evidence from the lien claimant affirmatively establishing that its charges were reasonable, the WCJ properly relied on the persuasive evidence submitted by defendant to determine that a fee of \$4,700.00 is reasonable.

## **B. Costs**

*Barr v. WCAB/Department of Industrial Relations, Subsequent Injuries Benefit Trust Fund v. WCAB (Dorigo)* (2008) 73 CCC 763, Court of Appeal, Third Appellate District.

Applicant Barr filed an Application against the Subsequent Injuries Benefit Trust Fund (SIF) and hired a vocational rehabilitation consultant to evaluate his condition. Without a trial or testimony, SIF ultimately stipulated to 100 percent PD, but objected to payment of the fees of the vocational rehabilitation consultant. The WCJ allowed the cost of the consultant's time to prepare for testimony but not the cost of preparation of the consultant's report on the ground that the report was not admissible under Labor Code §5703. The WCAB affirmed and the Court of Appeal denied SIF's Petition for Writ of Review, but granted Barr's petition.

Similarly, applicant Dorigo filed a claim against the SIF and obtained the services of a vocational consultant. He also settled his case without a trial. However, contrary to Barr,

a different WCJ determined that the cost of the report was reasonably and necessarily incurred and awarded it as a cost under Labor Code §5811. The WCAB affirmed and the Court of Appeal granted SIF's petition in order to address the question of whether the Board has the discretion to award costs for the preparation of a vocational rehabilitation consultant's report whether or not the report is admissible.

The Court first noted that Labor Code §5811 confers on the WCAB the discretion to award costs. Secondly, it agreed with the WCAB that §§5708 and 5709 provide the context within which it exercises its discretion. Section 5708 provides that the WCAB "shall not be bound by the common law or statutory rules of evidence and procedure, but may make inquiry in the manner, through oral testimony and records, which is best calculated to ascertain the substantial rights of the parties and carry out justly the spirit and provisions of this division." Section 5709 provides that "[n]o informality in any proceeding or in the manner of taking testimony shall invalidate any order, decision [or] award. No order, decision, [or] award shall be invalidated because of the admission into the record, and use as proof of any fact in dispute, of any evidence not admissible under the common law or statutory rules of evidence and procedure." Thus, the WCAB is unencumbered by formality or traditional rules of evidence and procedure.

The Court disagreed with SIF's contention that the WCAB's discretion to award costs is limited by Labor Code §5703 which lists various types of documents that are admissible into evidence. Whether or not the report was admissible was irrelevant because the issue before the Court was not the admissibility of the report but whether the WCAB had discretion to award costs pursuant to §5811 even if the report itself was inadmissible. The Court cited *Costa v. Hardy Diagnostic* (2007) 72 CCC 1492 (Appeals Board en banc), in which the vocational rehabilitation consultant's report was excluded from evidence. Nevertheless, the cost was allowable under §5811 under standards analogous to medical-legal costs. *Costa* reflects the legislative policy to accord the WCAB the discretion to evaluate whether the costs of a vocational rehabilitation consultant's report are reasonable and necessary based on the facts of the particular case before it.

Thus, the Court remanded the Barr case to the WCAB to exercise its discretion to award the costs of the report even if it might have been inadmissible and affirmed the WCAB's award of costs in the Dorigo matter.

*California Nurse Life Care Planning v. WCAB (Escobedo)* (2008) 73 CCC 1529, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant suffered a catastrophic injury that necessitated 24 hour care to assist him with the activities of daily living. defendant admitted liability and provided benefits. Applicant's attorney engaged Petitioner to prepare a Life Care Plan projecting the current and future costs associated with applicant's medical and non-medical needs. According to Petitioner, the purpose of the Life Care Plan was to "assess the value of the case and assist the parties in reaching an anticipated structured settlement." Petitioner ultimately filed a lien for its services in the amount of \$24,424.44.

The parties did not enter into a Compromise and Release, but instead agreed to a 100 percent PD award together with medical treatment which was approved. Defendant resisted payment of Petitioner's lien and the matter came on for trial. The WCJ denied reimbursement on the lien, concluding that the Life Care Plan was neither a medical-legal expense under Labor Code §4621(a) nor a valid cost under §5811. Adopting the WCJ's reasoning, the WCAB denied the lien claimant's Petition for Reconsideration.

The Court of Appeal found that the lien did not represent a valid medical-legal expense because it was not incurred for the purpose of proving or disproving a contested claim. There was no evidence of any disagreement between the parties relating to the value of applicant's future medical care.

Likewise, it was found that the lien did not represent a valid cost of litigation because there was no litigation. Petitioner argued that the WCAB abused its discretion in requiring that costs be "in connection with some aspect of the litigation," urging that such an interpretation was nowhere contemplated by the statute and violated Labor Code §3202. However, the Court noted that as long as the Board's findings were supported by inferences that may fairly be drawn from the evidence, the decision would not be disturbed, even though the evidence was susceptible of opposing inferences.

The Court also stated that it was "unconvinced that requiring an employer to provide a \$24,424.44 cost-projection report promotes the constitutionally declared public policy of resolving workers' compensation cases as inexpensively as possible." Thus, the petition for writ of review was denied.

### **XIII. Vocational Rehabilitation**

*Medrano v. WCAB* (2008) 73 CCC 1407, Court of Appeal, Second Appellate District, Division Five.

Defendant rejected applicant's claim for vocational rehabilitation based on his employer's offer of modified or alternative work. The Rehabilitation Unit (RU) determined that applicant was entitled to full vocational rehabilitation services and retroactive VRMA, on a wage-loss basis until a qualified rehabilitation representative (QRR) evaluated the offer of modified/alternative work for compliance with the regulations. Defendant appealed the RU's determination. At the hearing on the appeal, applicant testified that he last worked for the employer in 2002 and went to work for another company in 2005, where he continued to work. The WCJ found that the offer of modified/alternative work was not appropriate and awarded applicant rehabilitation services and retroactive VRMA up to the date that he returned to the labor market in 2005.

The WCJ set aside his Findings and Award and reopened the record in light of the recent appellate opinion in *Gamble v. WCAB* (2006) 71 CCC 1015, in which it was held that an employer could not take a credit against VRMA for wages earned at a secondary, concurrent employment. After a second hearing, the WCJ awarded VRMA at the delay

rate, on a continuing basis until applicant either completed a vocational rehabilitation plan or refused to enter into a plan, or it was found that he was not “feasible” to participate in such a plan, whichever occurred first. Citing *Gamble*, the WCJ also concluded that defendant was not entitled to credit for wages earned by applicant in subsequent employment during the period of time he was awarded VRMA.

Defendant filed a Petition for Reconsideration, contending it had met its obligation to provide vocational rehabilitation services, and alternately, if required to pay VRMA, it was entitled to full credit for wages earned against any VRMA that might be due. In an Opinion and Order After Reconsideration, the WCAB agreed with the WCJ’s decision that applicant was entitled to full vocational rehabilitation services. However, it also determined that the amount of his earnings from subsequent employment must be subtracted from the VRMA to which he was entitled. Defendant then sought judicial review.

The Court of Appeal identified the issue as follows: whether VRMA is merely one among the array of vocational rehabilitation services available to workers and thus not subject to a credit for wages or, whether VRMA serves the same purpose as, and is a form of, TD, and therefore would be a wage-loss benefit subject to a credit.

The Court first commented that the holding in *Gamble* carries out the policy of the workers’ compensation statutes to promote “a pervasive and abiding solicitude for the workman.” Here, the RU, the WCJ, and the Board determined that defendant had not made a bona fide offer of vocational rehabilitation services that complied with applicable regulations. While his eligibility was being disputed, applicant was not receiving VRMA. Thus, he should not be penalized for obtaining work to provide him with compensation under these circumstances. And the defendant should not be the beneficiary of the work applicant undertook, because it was defendant’s denial of services that resulted in applicant needing to work.

While the facts were somewhat different from those in *Gamble*, the Court did not find a practical difference between a worker who earned wages at a position that pre-existed the injury, and a worker who earned wages at a position secured after the injury. Furthermore, it did not find VRMA to be a form of TD, but rather a benefit substantially different from TD. VRMA is paid at an amount less than TD, for a limited period of time, and in a limited amount. Finding VRMA not to be a wage replacement benefit, the Court annulled the decision of the WCAB.

*Galvao v. WCAB* (2008) 73 CCC 1639, Court of Appeal, First Appellate District, Division Two, unpublished opinion.

When she was released to return to work following her industrial injury, applicant obtained less physically demanding work with a different employer. A dispute arose as to whether she was a qualified injured worker (QIW). The Rehabilitation Unit (RU) found that she was medically eligible for vocational rehabilitation and entitled to retroactive

VRMA at the delay rate. Additionally, the RU ruled that defendant was entitled to a credit against the VRMA benefits for wages applicant received from her other employer.

Both parties appealed the Determination of the RU. After trial, the WCJ upheld the RU's rulings that applicant was a QIW and was entitled to vocational rehabilitation services, including VRMA benefits at the delay rate. The WCJ ruled, however, that, under *Gamble v. WCAB* (2006) 71 CCC 1015, the defendant was not entitled to a credit for wages she received from her other employer.

Defendant filed a petition for reconsideration which was granted by the WCAB. The Board upheld the WCJ's determination that Galvao was a qualified injured worker and was entitled to VRMA benefits at the higher delay rate but modified the award to provide that defendant was entitled to a credit against the VRMA benefits for wages applicant earned working for her subsequent employer. The Board ruled that *Gamble* did not preclude the allowance of a wage credit because it could be distinguished on the facts, observing that the VRMA benefits in *Gamble* were paid at the ordinary rate rather than the delay rate, and the employee in *Gamble* was already working at his second job before his injury. Applicant filed a petition for writ of review which was granted by the Court.

The Court noted that after the petition for writ of review and answer had been filed in this case, a different appellate district decided *Medrano v. WCAB* (2008) 73 CCC 1407 in which *Gamble* was applied to defeat the credit for wages the applicant earned in employment obtained subsequent to the for the wages Medrano earned in employment he obtained subsequent to his injury.

In addition to arguing that *Gamble* is distinguishable, defendant suggested that the *Gamble* Court was incorrect in concluding that VRMA "is not intended to replace lost earnings." However, the Court concluded that the case defendant relied upon was no longer good law having been superseded by two more recent cases that came to the opposite conclusion.

Defendant also argued that *Gamble* was distinguishable based on the fact that applicant, unlike *Gamble*, was awarded VRMA benefits at the delay rate. However, the Court in *Medrano* held that no wage credit was permitted even though Medrano, like this applicant, received VRMA benefits at the delay rate.

Lastly, defendant contended that *Medrano* was incorrectly decided. The Court disagreed, noting that the *Gamble* Court had concluded, as a matter of statutory interpretation, that no wage credit applies to VRMA because VRMA, unlike TD and VRTD, is not intended to replace lost earnings.

The Court annulled the Board's decision is annulled, and reinstated the decision of the WCJ.

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

*Hertz Corporation v. WCAB (Aguilar)* (2008) 73 CCC 1653, Court of Appeal, Sixth Appellate District.

Applicant, an immigrant worker who was not conversant in English, sustained three orthopedic injuries involving multiple body parts while employed as a car washer. QMEs reporting for both parties indicated that he had a PD rating of around 60 percent. Applicant was referred for vocational rehabilitation but was found not to be feasible because of his chronic pain and lack of English skills.

Relying on *LeBoeuf v. WCAB* (1983) 48 CCC 587, the WCJ found applicant to be 100 percent permanently disabled based on the trial testimony of two independent rehabilitation experts who agreed that “his educational background, his native intelligence, and his level of skill in the English language” “together with [his] physical impairment” render him “permanently unemployable.” Defendant’s petition for reconsideration was denied by the WCAB which adopted the report and recommendation of the WCJ.

Defendant sought judicial review, contending that an employer should not be liable for permanent total disability benefits where the determination that an injured worker is not feasible for vocational rehabilitation is due, in part, to nonindustrial causes. The Court of Appeal agreed and found no evidence in the record to support the Board’s finding that applicant’s industrial injuries directly caused him to be 100 percent permanently disabled. The QME reports rated out to 60 percent. The rehabilitation counselors agreed that applicant’s disability, standing alone, did not make him unemployable.

The Court noted that *LeBoeuf* remains good law in situations where an employee is found non-feasible for rehabilitation due to disability directly caused by an industrial injury, and not where the non-feasibility finding is due in part to preexisting nonindustrial factors or conditions. The revised workers’ compensation system precludes such a holding. An employer may only be found liable for PD directly caused by the industrial injury and apportionment is now based on causation, so an employer may properly obtain apportionment of PD to factors that are not disabilities. Therefore, the Board’s finding of 100 percent PD was annulled, and the matter remanded for a redetermination of applicant’s PD rating.

One justice wrote a concurring opinion in which he agreed with the majority’s judgment in this particular case but expressed concern over the potential for overbroad application, especially in the case of industrially injured unskilled workers. He also expressed concern over the majority’s apparent reliance on a writ denied case and wrote an excellent critique of the use of writ denied cases as authority.

Note: The Court appears to be saying that an employer may properly obtain apportionment of PD to factors that are not disabilities, such as educational background, native intelligence, and level of skill in the English language.

## B. Application of Proper PDRS

*Lewis v. WCAB* (2008) 73 CCC 1668, Court of Appeal, Third Appellate District.

Applicant suffered an admitted injury to his low back in 2004. The matter proceeded to trial on the single issue of whether the new 2005 PDRS or the old 1997 PDRS applied to the determination of his PD. Applicant maintained that the 1997 Schedule was applicable to his case because a December 17, 2004 treating physician's report states that he cannot "return to his usual and customary job duties" and that "[v]ocational rehabilitation efforts are indicated." This report, he argued, brought his case under the exception in Labor Code §4660(d) where there is a pre-January 1, 2005, treating physician's report "indicating the existence of permanent disability."

The WCJ found that the 2005 PDRS applied because the doctor had not specifically linked the need for rehabilitation to applicant's 2004 industrial injury, presumably as opposed to a prior injury which had required surgery. Applicant petitioned for reconsideration and while his petition was pending, a different district of the Court of Appeal rendered its decision in *Vera v. WCAB* (2007) 72 CCC 1115. Relying solely on *Vera*, which was the only published decision on the issue at the time, the WCAB denied Lewis's petition for reconsideration on the ground that the report did not indicate that applicant's disability became permanent and stationary prior to January 1, 2005.

Applicant then sought judicial review which was summarily denied. However, the Supreme Court granted review and transferred the matter back to the Court of Appeal with directions to issue the writ of review. The high Court's order cited *Genlyte Group, LLC v. WCAB (Zavala)* (2007) 73 CCC 6, and *Zenith Insurance Company v. WCAB (Cugini)* (2008) 73 CCC 81, two decisions critical of *Vera*.

The *Vera* Court had concluded that a treating physician does not "normally" address the issue of permanent disability until an injured worker is permanent and stationary; and the terms "permanent disability" and "permanent and stationary status" are used interchangeably in the applicable administrative regulations. The Court rejected the *Vera* rationale and agreed with *Genlyte* and *Zenith* which held that if the existence of permanent disability is indicated in a pre-2005 treatment or medical-legal report, considered in light of the entire record, then the 1997 Schedule will apply.

Thus, the decision of the WCAB was annulled and the matter was remanded to the WCAB to determine whether the December 17, 2004 treating physician's report was substantial evidence "indicating the existence of permanent disability" arising out of applicant's industrial injury, based on the entire record.

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*Newlands v. WCAB* (2008) 73 CCC 1010, Court of Appeal, Third Appellate District, unpublished opinion.

Applicant sustained upper extremity injuries in her employment. She underwent surgery in January and November of 2003. In June 2004, her treating physician expressed the opinion that while she had not yet reached maximum medical improvement, she was “permanently disabled due to bilateral hand dysfunction . . . and thus is not suitable for any specific kind of employment and this again is a permanent work restriction.”

She was evaluated by a QME (whom the Court also refers to as an AME) in 2003. He reserved judgment pending further evaluations and finally declared her condition to be permanent and stationary in February 2005. In March and June of 2005, defendant obtained surveillance videos of applicant performing various activities with her upper extremities without apparent signs of discomfort. After viewing these videos, the QME (or AME) reported that they reinforced his opinion that applicant did not have the pain syndrome, and raised credibility issues regarding her subjective reports of pain. However, he explained in a later deposition, that this did not alter his opinion on the degree of her disability, because the finding of disability is almost automatically warranted after the 2003 surgeries she underwent

The WCJ found in his decision that the pre-2005 opinions of the employee’s treating physicians did not provide substantial evidence of the existence of a permanent disability. He found the treating physician’s characterization of her condition as permanent to be at odds with his continuing recommendations for further treatment. He also found it to be problematic that the doctor had never seen the surveillance videos. He was concerned that contrary to the opinions of the treating physicians, the QME or AME did not think she had complex regional pain syndrome. The WCAB adopted the decision of the WCJ and denied applicant’s petition for reconsideration. She then sought judicial review.

The Court of Appeal noted that in *Genlyte v. WCAB*, the Court explained at length that an “‘indicat[ion of] the existence of permanent disability’” is *not* synonymous with a finding that the disability is “permanent and stationary.” The term “‘permanent disability’” indicates an impairment, while the term “‘permanent and stationary’” is a conclusion in the context of medical rehabilitation. It also indicates the time when the PD can be rated and TD payments end. However, nothing prevents a treating physician from indicating the existence of a permanent disability of a yet-to-be-rated extent in a report, and compensation practice and jurisprudence both acknowledge a status of permanent disability that precedes the point when it is “‘permanent and stationary.’”

As a result, the Court found, the Board applied the wrong standard in determining that the reports of the treating physician did not provide an indication of the existence of a permanent disability because he also indicated the need for further treatment. As the QME or AME stated, the nature of the surgery of itself would be a basis for finding applicant to have a permanent disability under the standards prevailing at the time and the presence of absence of a pain syndrome did not detract from the doctors’ identification of an underlying impairment in function of some unspecified degree.

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Thus, the matter was remanded to the WCAB to determine in the first instance whether, “shorn of mistaken interpretive filters,” they adequately indicate the existence of a permanent disability, “as likely as that may seem to [the Court.]”

*Payless Shoe Source v. WCAB (Dalerio)* (2008) 73 CCC 1018, Court of Appeal, Fifth Appellate District, unpublished opinion.

In July 2004, applicant asserted a workers’ compensation for cumulative trauma through her last date of employment in August 2003. Pursuant to a December 19, 2005 AME report, the WCJ found that applicant was TTD from August 17, 2003, through February 15, 2004, and awarded her TD for that period. The WCJ then concluded the 1997 PDRS applied because defendant should have provided her with a final TD payment before January 1, 2005.

Defendant filed a petition for reconsideration, claiming that the 2005 PDRS instead applied. In his report, the WCJ explained he relied on the AME’s opinion that applicant became permanent and stationary six months after August 16, 2003, and therefore the “notice requirement under Labor Code section 4061 more likely than not would have arisen around 02/15/04.” The WCAB denied reconsideration, adopting the WCJ’s report. Defendant then filed a petition for writ of review.

The Court of Appeal noted that the AME’s report was not prepared until after the 2005 PDRS went into effect, and the parties did not point to any evidence in existence before January 1, 2005, that would have placed defendant on notice that any TD benefits were both payable and should have terminated before January 1, 2005. Applicant argued that an employer could delay “picking up” a pre-2005 disability claim so as to unfairly hinder an employee’s ability to obtain a medical-legal evaluation before 2005. However, the Court noted that it was applicant who delayed almost a year in bringing her claim and that nothing prevented her from seeking, before January 1, 2005, a “report by a treating physician indicating the existence of permanent disability” that would have triggered the use of the 1997 PDRS.

The Court remanded the matter to the WCAB to determine whether a report of a treating physician indicated the existence of permanent disability, thereby warranting the use of the 1997 PDRS. The Court noted that if the record is void of such evidence prepared before January 1, 2005, then applicant’s permanent disability must be rated under the 2005 PDRS.

*Service Rock Products v. WCAB (Marquis)* (2008) 73 CCC 1307, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant was injured in April 2004. Defendant furnished TD benefits. He underwent surgery and was released to return to work on a trial basis on August 25, 2004. On September 3, 2004, defendant provided applicant with the requisite notice under Labor Code §4061. Applicant worked for a couple of weeks and was then placed back on TD.

The WCJ awarded TD from April 26, 2004, through November 6, 2006, less the time he worked in August and September 2004. He also concluded that applicant's PD rating must be based on the 1997 PDRS, because the §4061 notice requirement was triggered prior to January 1, 2005. Defendant petitioned for reconsideration, but the WCAB denied the petition based on the report and recommendation of the WCJ. It then sought review in the Court of Appeal.

Defendant asked the Court to determine whether the 1997 PDRS must apply if there was a triggering event suggesting that an employer was obligated to give notice per Labor Code §4061, but a trier of fact ultimately determines that as a matter of law, the applicant had remained TTD, thus obviating the requirement to send a §4061 notice. The Court's response was that defendant actually sent the §4061 notice and the fact that applicant became eligible for further TD does not retroactively dissolve its prior obligation to notify applicant that his benefits were ending.

Defendant also suggested that the §4061 notice requirement never truly arose because the WCJ found applicant was not permanent and stationary until November 2006. However, an employer's obligation to send the §4061 notice is not attached to whether an injured employee is actually permanent and stationary, but instead arises when the employer believes TD indemnity is no longer warranted.

The petition for writ of review was denied.

*Virginia Surety Company v. WCAB (Echelard)* (2008) 73 CCC 1218, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant was injured when he fell 20 feet to a concrete floor on October 29, 2004. Defendant furnished applicant with medical treatment and TD payments, but disputed whether his PD should be rated under the 1997 or 2005 PDRS. The WCJ concluded that the 1997 PDRS applied, finding that pre-January 1, 2005, medical reporting from two treating physicians indicated the existence of permanent disability.

Defendant petitioned for reconsideration. The WCJ explained in his report that he had based the decision on the recently published decisions in *Genlyte Group, LLC v. WCAB (Zavala)* and *Zenith Ins. Co. v. WCAB (Cugini)*. The WCAB agreed that the 1997 schedule applied but that only one of the doctors' reports indicated the existence of permanent disability. Defendant then sought judicial review.

Defendant argued that even assuming that permanent and stationary status is not required to satisfy Labor Code § 4660(d)'s 'permanent disability' requirement, there was still no report prior to January 1, 2005 which indicates with substantial medical probability that the applicant either is permanently disabled or even that he is going to be permanently disabled." While the Court agreed that the report must be in existence before 2005, it disagreed that the WCAB may not consider any subsequent explanation concerning the same report from the authoring physician.

Here, the treating physician stated in a report of December 20, 2004, “I spent quite some time trying to discuss with [applicant] and his mother the significance of these injuries and the relatively guarded prognosis.” Discussing the above reporting during his July 24, 2007, deposition, the doctor explained that his reference to a “relatively guarded prognosis” referred to applicant’s “potential for some decrease or loss of motion and subsequent decrease and loss of function, and potentially the possibility of ongoing pain; and the fact that, with this type of injury, this far after the injury the results of surgical treatment would probably not be extremely good.” The doctor also expressed the opinion he did not believe applicant would heal completely.

The Court agreed with the WCAB that the record contained a pre-2005 indication of permanent disability and denied the writ.

*City of Fresno v. WCAB (Wilson)* (2008) 73 CCC 1401, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant injured her back and claimed injury to other body parts on June 25, 2003. The matter came on for trial on the limited issue of whether the case should be rated under the 1997 or 2005 PDRS. Applying *Vera v. WCAB* (2007) 72 CCC 1115, the WCJ concluded applicant injury must be rated under the 2005 PDRS because she had not been medically declared permanent and stationary.

The WCAB granted applicant’s petition for reconsideration and found that the former PDRS applied because a February 2004 report of the treating physician provided an indication applicant had sustained some level of PD. Acknowledging that the WCJ properly relied upon *Vera* at the time of issuing the decision, the WCAB concluded the more recent decisions in *Genlyte* and *Zenith* “provide the more persuasive analysis and should be followed.” Defendant then sought judicial review.

The Court of Appeal agreed with the WCAB. The treating physician’s opinion, couched in terms of reasonable medical probability, indicated that applicant would probably not be able to engage in heavy lifting, repetitive bending, or stooping even after she became permanent and stationary. Moreover, the doctor concluded she would most likely not be able to return to her former line of work and that she would require vocational rehabilitation. The Court found that sufficient evidence therefore existed for the WCAB to find a pre-2005 “indication of permanent disability” warranting the use of the 1997 PDRS. The petition for writ of review was denied.

*Sensient Technologies Corporation v. WCAB* (2008) 73 CCC \_\_\_, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant claimed a specific injury of 2003 and a cumulative trauma ending in 2005 when he retired at the age of 61. At trial, applicant’s attorney made an offer of proof that applicant would testify that he retired because he could not do his work duties and not because he intended to take himself out of the labor market. The parties then agreed that the matters could be submitted on the existing record without live testimony. The WCJ

found TD as a result of the 2005 injury. With respect to the 2003 injury, it was found that 1997 PDRS was applicable. Defendant petitioned for reconsideration and the WCAB denied the petition, adopting the WCJ's report and recommendation.

Regarding the TD award, the defendant asked the Court to disregard applicant's "self-serving" statement regarding the reasons for his retirement and rely instead on the history in an AME report that he lost no time from work and retired in July 2005. The Court noted that no legal authority was presented for the proposition that an offer of proof may not constitute substantial evidence to support a finding of fact and that if defendant was concerned about the veracity of the offer of proof, it should have cross-examined applicant. Furthermore, the statement in the AME report did not necessarily rebut the offer of proof.

Defendant disputed the applicability of the 1997 PDRS for the 2003 injury because at the time of the QME report on which the WCJ relied, applicant was not yet permanent and stationary. The Court noted that at least one appellate case has held that an employee must be permanent and stationary before a medical opinion could indicate an existence of permanent disability within the meaning of Labor Code §4660(d). However, it felt that the greater weight of judicial authority and the line of cases with which it agreed, hold that a pre-2005 medical determination of permanent and stationary status is *not* required to rate a disability under the 1997 PDRS. Defendant did not offer any authority to dispute the WCAB's determination that the QME report sufficiently indicated the existence of permanent disability warranting the use of the 1997 PDRS.

Thus, the Petition for Writ of Review was denied and the case was remanded to the WCAB to issue a supplemental award of reasonable fees to applicant's attorney based on the services rendered in connection with answering the petition.

*Muraoka v. WCAB (4/28/09) WCC 35182009 CA; Not for Publication; 2<sup>nd</sup> App. Dist.*

Applicant sustained a cumulative trauma injury from 1998 to September, 2003 to her spine and both upper extremities, while employed as a clerk/typist for the City of Los Angeles. Dr. Nagelberg performed bilateral CTS releases in May, 2004 and July, 2005. At trial, the judge relied upon the treating records and Dr. Nagelberg to determine injury AOE/COE. The parties also disputed which PDRS should apply. The 2005 schedule provided a rating of 32%, while the 1997 schedule provided a 68% rating. The judge applied the 2005 schedule finding there was no substantial medical evidence showing the existence of permanent disability or a permanent loss of functional capacity before 2005.

The decision was upheld on reconsideration. Applicant filed a petition for writ of review. The 2<sup>nd</sup> District reviewed the medical evidence and cited a report from April, 2004 noting that "within a reasonable medical probability" the Applicant suffered a permanent disability as a result of the CT claims. The court cited other medical records prior to April 2004 showing the symptoms did not improve and surgery was requested in December, 2003.

The record reflected Dr. Nagelberg had not examined the applicant between December, 2003 and April 28, 2004. The court noted a licensed certified physician's assistant examined the applicant and discussed the findings with the doctor. Dr. Nagelberg's recommendations accompanied each PA's report.

The court cited *Zenith Insurance Co. v. WCAB (Cugini)* (2008) 159 Cal. App. 4<sup>th</sup> 483, 73 CCC 81 for the proposition that the Board must determine whether there is medical evidence of PD under LC 4660(d); is substantial evidence; does not require P&S status; whether there is an indication of existence of PD. Further, a PA's examination findings preclude the physician's opinion from constituting substantial evidence.

### C. Validity of PDRS

*Boughner v. Comp USA, Inc.* (2008) 73 CCC 854, Appeals Board en banc decision.

In the Findings and Award that issued in applicant's case, the WCJ found, among other matters, that:

- (1) "The [AD] failed to base the adjusted rating schedule on empirical data and findings from the Evaluation of California's Permanent Disability Rating Schedule, Interim Report (December 2003), prepared by the RAND Institute for Civil Justice, as required by Labor Code §4660(b)(2);"
- (2) the AD "failed to base the adjusted rating schedule on data from empirical studies, as required by §4660(b)(2);" and
- (3) "The DFEC [diminished earning capacity factor] Adjustment Factors set forth under the new Permanent Disability Rating Schedule (PDRS) adopted January 1, 2005 at page 1-7, Table A are inconsistent with the authorizing statute, §4660(b)(2) and therefore invalid."

Based on these last three findings, the WCJ found that "the applicant has rebutted the presumptive validity of the PDRS adopted January 1, 2005." The WCJ then deferred all remaining issues.

Previously, in *Costa v. Hardy Diagnostic* (2006) 71 CCC 1797, the Appeals Board held, en banc, that on the record before the Board in that case, the applicant had not met his burden of proving the new PDRS invalid.

Defendant filed a petition for reconsideration, and in the alternative, a petition for removal, contending that (1) the WCJ erred by not following relevant, binding precedent set forth in the en banc decision in *Costa*; (2) the WCJ erred in finding that the AD's actions were "arbitrary and capricious;" (3) the WCJ "relied on 'expert' testimony that is unreliable and biased, and improperly concluded that the testimony warranted a departure from binding precedent;" and (4) "the necessity and usefulness of a 'crosswalk study' has

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been over-promised, and in any event such studies were not available prior to the implementation of the new PDRS.”

Applicant filed an answer to the defendant’s petition, contending that (1) the WCJ correctly distinguished *Costa* from the instant case; (2) the WCJ did not commit error in finding that the AD’s actions were arbitrary and capricious; and (3) “the intent of the Legislature could not be achieved without a ‘crosswalk study’ which was unilaterally cancelled by the AD.”

In response to the WCJ’s report and recommendation that reconsideration be denied, the Administrative Director (AD) submitted her “Memorandum of Points and Authorities in Support of Defendants’ Petition for Reconsideration,” in which she contended that (1) the validity of the 2005 PDRS has already been decided by the WCAB in the unanimous en banc decision in *Costa*; (2) “the evidentiary record in the reviewing court when evaluating the validity of a regulation is limited to the rulemaking record; extra-record evidence should not be admitted;” and (3) there is nothing in the record that would distinguish this matter from the *Costa* precedent which upholds the validity of the PDRS. She also requested that judicial notice be taken of certain documents. Both applicant and defendant filed responses to the AD’s Memorandum.

The WCAB first concluded that as a matter of law, the Board has sole original jurisdiction to consider the validity of the new PDRS, adopted by the AD through a regulation. It then addressed the standards for rebutting the presumptive validity of an administrative regulation. The Board noted that its task was to inquire into the legality of the regulation, and not its wisdom, or more specifically, to determine whether the regulation is within the scope of the authority conferred and is reasonably necessary to effectuate the purpose of the statute.

Moreover, in considering whether the regulation is “reasonably necessary,” the Board may not superimpose its own policy judgment upon the agency in the absence of an arbitrary and capricious decision which is defined as one that is entirely lacking in evidentiary support. The party challenging the regulation has the burden of demonstrating its invalidity and, in order to carry this burden, that party must demonstrate that the regulation is arbitrary and capricious.

In *Costa*, the Board rejected the contention that the AD failed to base the adjusted rating schedule on empirical data and findings from the RAND 2003 Interim Report and therefore concluded that the applicant had failed to meet his burden of proving the 2005 PDRS invalid. The Board did not specifically uphold the validity of the new PDRS, but held, in effect, that applicant did not disprove its validity. The record here differed from that in *Costa* as it included the deposition testimony of Rand expert Dr. Reville and the deposition and trial testimony of consultant Mark Gerlach.

The AD had pointed out that when evaluating the validity of a regulation, the evidentiary record in the reviewing court is limited to the rulemaking record and that extra-record evidence should not be admitted. The Board found that the case law supported the AD’s

position which had not previously been raised as an issue. Nevertheless, even assuming that the evidence presented, which was admitted without objection, was properly in the record, the Board concluded that neither the testimony of Dr. Reville nor that of Mr. Gerlach served to rebut the presumptive validity of the 2005 PDRS. The Board also rejected the WCJ's findings concerning the utilization of empirical data in formulating the 2005 PDRS.

Lastly, while Mr. Gerlach testified at trial that a crosswalk study could have been completed and utilized in time to meet the January 1, 2005 statutory deadline, the Board found this testimony to have been contradicted by the testimony of both the AD and Dr. Reville, and to be unsupported by reference to any facts or data.

In conclusion, the Board found on the record in this case that applicant had not carried his burden of demonstrating that the AD's adoption of the 2005 PDRS was arbitrary and capricious, or inconsistent with Labor Code §4660(b)(2). Accordingly, it reversed the determination that applicant rebutted the presumptive validity of the 2005 PDRS, and returned the matter to the trial level for further proceedings and decision on all outstanding issues.

## **XV. Apportionment**

### **A. Labor Code §4663**

*Mills v. WCAB* (2008) 73 CCC 812, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant sustained multiple orthopedic injuries when he fell from a scaffold. He also claimed that the injury aggravated his prior respiratory problems which defendant denied. Shortly after the injury, applicant became confined to a wheelchair. An AME expressed the opinion that the combination of the industrial injury and the pulmonary condition rendered applicant totally disabled, of which the nonindustrial pulmonary condition was 60 percent responsible. Relying on the AME's opinion, the WCJ found that applicant was 40 percent permanently disabled as a result of the industrial orthopedic injury and 60 percent permanently disabled as a result of his nonindustrial pulmonary condition which the WCJ concluded was not aggravated by the industrial injury.

Applicant petitioned for reconsideration, contending the new apportionment provisions of Senate Bill No. 899 could not be interpreted to allow for disabilities that develop after the industrial injury in a different region of the body, and that the opinion of the AME didn't constitute substantial evidence. The WCJ recommended that reconsideration be denied. However, the WCAB granted reconsideration and issued its own opinion adding additional reasoning to the WCJ's report and recommendation.

Applicant contended that Senate Bill No. 899 did not repeal the Court of Appeal's decision in *Fresno Unified School District v. Workers' Comp. Appeals Bd. (Humphrey)*, (2000) 65 CCC 1232, allowing apportionment to a subsequent nonindustrial injury overlapping with an industrial injury. The Court indicated that it was perplexed by this argument since Humphrey was an interpretation of Labor Code §4750.5 that was repealed by SB 899 and the facts were completely different.

The Court noted that he appeared to be arguing 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 orthopedic and pulmonary conditions should be entirely or largely attributable to his employment. The Court disagreed, noting that the elimination of such liability for "lighting up" a nondisabling preexisting condition, was the very change intended by the Legislature in revising the apportionment statutes.

Although applicant attacked the AME for purportedly failing to understand the law of apportionment, he did not specify with detail how the doctor misunderstood or misapplied the law in reaching his medical conclusion that 40 percent of applicant's total permanent disability was caused by his industrial injury. The Court found no good reason to reject the opinion of an AME who was mutually selected by the parties because of his expertise and neutrality. Therefore, the petition for writ of review was denied.

*E & J Gallo Winery v. WCAB (Rubio)* (2008) 73 CCC 1206, Court of Appeal, Fifth Appellate District, unpublished opinion.

The WCJ issued a Findings and Award finding that applicant sustained an injury to his left shoulder that caused PD of 15 percent and that there was no basis to apportion the award to any prior injury. Defendant filed a petition for reconsideration contending that the WCJ failed to consider a prior 11 percent PD award for an upper back injury which applicant did not reveal despite defendant's demand for disclosure.

In his report and recommendation, the WCJ explained there was no evidence in the record that applicant actually received a prior 11 percent PD award and even if he did, defendant did not demonstrate that the prior disability overlapped with his current disability. Adopting the WCJ's report, the WCAB denied reconsideration. Defendant then sought judicial review.

The Court of Appeal noted that defendant never offered any definitive evidence into the WCAB record that a prior award existed, relying entirely on a comment in a medical report that applicant "apparently" received such an award but that he denied it. Although defendant blamed applicant for not producing the prior award, the burden of proof was on defendant as the one standing to benefit from such evidence. The Court noted that this burden was particularly applicable in the present case since applicant was working for defendant at the time of the prior injury. Therefore, if a prior PD award existed, defendant "should not have needed to search beyond its own employment files."

Defendant's QME found apportionment, but only under Labor Code §4664. He did not set forth approximate percentages of PD as required by §4663. Additionally, the doctor failed to state in his report how the disabilities overlapped. Thus, defendant failed to carry its burden of proof that applicant's PD was subject to apportionment and the petition for writ of review was denied.

*Department of Corrections and Rehabilitation v. WCAB (Alexander)* (2008)  
73 CCC 1294, Court of Appeal, Fifth Appellate District.

Applicant, who was employed as a correctional officer in a state prison until July 2005, asserted a workers' compensation claim that included an injury to his cardiovascular system. As a public safety officer, he was entitled to a presumption of compensability under a statute that also provided that "the injury or illness could not be attributed to any preexisting disease."

When SB 899 was enacted in 2004, new Labor Code §4663 was enacted to provide that every PD award must be apportioned to the extent that the disability did not arise out of and in the course of employment. Subsequently, in 2006, the Legislature amended §4663 by adding subdivision (e) which provides that Labor Code §§3212 through 3213.2 shall not apply to injuries or illnesses covered under those Labor Code sections granting the public safety officer presumption. An uncodified section of the enacting legislation provides: "It is the intent of the Legislature that this act be construed as declaratory of existing law."

The matter came on for trial and the parties litigated the issue of whether section 4663(e) was in effect before January 1, 2007, and would thus serve to bar apportionment of that part of applicant's PD that had accrued as of then. The WCJ and the WCAB answered the question in the affirmative. Defendant then filed a petition for writ of mandate and/or prohibition with the Court of Appeal. The Court chose to treat the petition as a petition for writ of review and issued the writ.

The Court first noted that a statute that merely clarifies, rather than changes, existing law does not operate retrospectively even if applied to transactions predating its enactment because the true meaning of the statute remains the same. But if the amendment changed the law, the question of retroactivity arises. The Legislative Counsel's Digest of AB 1368 made it clear that §4663 was not intended to repeal the non-attribution presumptions of §§3212 through 3213.2 and did not do so by implication. Therefore, when the Legislature stated that §4663(e) declared existing law, it spoke accurately and the WCAB correctly declined to apportion Alexander's heart injury.

Petitioner argued that the WCAB's decision greatly increased its liability to similarly situated permanently disabled employees, thus unfairly imposing "new, unbudgeted burdens" on petitioner. However, the Court rejected that argument, responding that "[I]f petitioner now risks financial hardship because it miscalculated its obligations under the

law, it must address this concern “on the other side of Tenth Street, in the halls of the Legislature.”

*Forzetting v. WCAB* (2008) 73 CCC 1451, Court of Appeal, Second Appellate District, Division Six, writ denied.

Applicant sustained two industrial back injuries while working for the same employer. The parties agreed that applicant’s PD as a result of both injuries was 70 percent. However, the WCJ instructed the rater to perform separate calculations based on the Appeals Board’s en banc decision in *Benson v. Permanente Medical Group* (2007) 72 CCC 1260 and the AME’s apportionment opinion that 23 percent of the overall PD was attributable to the first injury and 47 percent to the second. The resulting F & A awarded applicant \$55,330 in PD benefits as opposed to the \$98,095 he would have received from a combined award.

Applicant filed a petition for reconsideration, contending that in *Benson*, the WCAB made an unconstitutional change to the law established by *Wilkinson v. WCAB* (1977) 42 CCC 406. The Board granted the petition to correct some clerical errors, but otherwise affirmed the WCJ. It noted that the Board does not have the power to declare a statute unconstitutional.

Applicant filed a petition for writ of review that was denied.

Note: After the denial of the writ, applicant filed a petition for review with the Supreme Court which granted the writ and transferred the matter back to the Court of Appeal to address what is essentially a challenge to the Appeals Board’s en banc decision in *Benson*. The writ issued on November 12, 2008.

*Allen v. WCAB* (2008) 73 CCC 1631, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant sustained a compression fracture of the L4 vertebrae necessitating a surgical fusion. She was evaluated by an AME who apportioned 20 percent of her overall disability to her preexisting pathology. The matter proceeded to trial and the WCJ awarded PD based on the 1997 PDRS, after apportionment. Defendant petitioned for reconsideration contending that the 2005 PDRS applied and the WCAB agreed and remanded the case to the WCJ for further proceedings.

At a trial following the remand, applicant presented the testimony of a vocational rehabilitation counselor who expressed the opinion that her “loss of future earnings capacity in the future is 100 percent as she has completely lost her ability to work in the future.” the WCJ found that the expert’s testimony did not overcome the 2005 PDRS because he did not consider any job but bookkeeper in opining she was precluded from the job market. He also found that the AME’s apportionment determination was not speculative and did not constitute age-based discrimination under Government Code

§11135. Both applicant and defendant filed petitions for reconsideration which were denied by the WCAB. Applicant then sought judicial review.

Applicant contended that the AME's apportionment was speculative. However, after reviewing the doctor's report and deposition testimony, the Court of Appeal concluded that his opinion was based on considerably more than mere speculation. He found objective medical evidence of underlying pathology and reviewed x-rays taken both before and after the industrial injury. While it was true the AME admitted he couldn't predict when applicant's pathology would have become symptomatic absent the industrial injury, an underlying pathology need not be labor disabling to be a valid basis for apportionment. The Court noted that the Legislature enacted the new apportionment provisions to eliminate the bar against apportionment based on pathology and asymptomatic causes.

Applicant contended that the AME's apportionment constituted age discrimination in violation of Government Code §11135. However, the Court agreed with the WCJ who stated the following: "While the doctor did say age was a factor in the pathology, he meant that people develop arthritis as they age. His apportionment was to [applicant's] specific medical conditions, and not simply to her being sixty years old."

Applicant additionally argued that the WCAB should have relied on the testimony of the vocational rehabilitation counselor to find that she was 100 percent permanently disabled pursuant to the holding in *LeBoeuf v. WCAB* (1983) 48 CCC 587. Even assuming *LeBoeuf* permits the WCAB to adopt a vocational rehabilitation expert's opinion of an employee's future earnings capacity in lieu of the PDRS, the expert's failure to consider jobs other than that of bookkeeper left the WCJ made it questionable that applicant was precluded from any future earnings at all. Furthermore, applicant waived the *LeBoeuf* issue by failing to raise it at trial following the remand. Thus the petition for writ of review was denied.

*City of Los Angeles v. WCAB (Johnson)* (2009) 74 CCC \_\_\_, Court of Appeal, Second Appellate District, Division One, unpublished opinion.

Applicant sustained various industrial injuries while working as a sanitation truck operator for the same employer for over 20 years. He injured his neck, back, and shoulders in 1975; his right shoulder in 1987; and his right knee in 1991. For these injuries, he received PD awards of 44 percent, 13 percent and 35 percent, respectively.

Thereafter, applicant claimed additional injuries, including his right side in 1991; his left knee in 1994 and 1995; and his right and left shoulders in 1996. He also claimed cumulative injury to the neck, back, shoulders, and knees as a result of performing his job duties from 1981 to 1998. These injury claims were evaluated by an AME who, in 1998, recommended work restrictions for the neck, back, shoulders, and knees and apportioned the PD to various injuries. He also assigned the same work restrictions to the left knee that were assigned to the right knee by a previous AME. He further found that all of applicant's injuries became permanent and stationary status at the same time.

The matter was submitted and the WCJ who issued rating instructions for all of the injuries and instructed the rater to apply *Wilkinson v. WCAB* (1977) 42 CCC 405. Based on the recommended rating, the WCJ issued a Joint F & A that provided for PD of 51 percent. Three months later, 2001, applicant filed a petition to reopen under the WCAB case number for the cumulative injury claim. He alleged that his condition had worsened, with need of further temporary and permanent disability, vocational rehabilitation benefits, and medical care.

Applicant returned to the same AME for additional evaluation. In 2002, the AME expressed the opinion that applicant's condition was remarkably similar to what was reported previously. However, in 2006, the doctor said that applicant's knees and shoulders had significantly worsened and his PD had increased. X-rays of applicant's knees showed severe degenerative disease and the AME apportioned 50 percent of the increased knee disability to the industrial history and 50 percent to the degenerative disease caused in part by applicant being 70 years old and weighing 360 pounds.

The parties proceeded to trial on the issue of apportionment under Labor Code §§4663 and 4664. They stipulated that 1) applicant had shown good cause to reopen his case for new and further disability." 2) Johnson previously received an award of 35 percent PD for the right knee injury of March 28, 1991. and 3) the increased PD reported by the AME was 89 percent. In a post-trial brief, defendant stated that no apportionment was allowed to the earlier stipulated Awards for the 1975 and 1987 injuries due to a finding that applicant had rehabilitated himself.

The WCJ issued an F & A finding good cause to reopen, and that the increased PD was 89 percent without apportionment under §§4663 and 4664. The Applicant was awarded PD totaling \$137,425, payable at \$230 per week, followed by a life pension at \$112 per week, with credit for indemnity previously paid. Defendant petitioned the WCAB for reconsideration, contending that there was no jurisdiction to award new and further knee disability because the petition to reopen was filed more than five years after the date of injury. The WCAB adopted the WCJ's decision and report and denied the petition for reconsideration. Defendant filed a petition for writ of review which was granted.

In its en banc decision in *Vargas v. Atascadero State Hospital* (2006) 71 CCC 500, the WCAB determined that the new apportionment statutes cannot be used to revisit or recalculate the level of PD, or the presence or absence of apportionment, determined under a final order, decision, or award issued before April 19, 2004. Contrary to the defendant's contentions, PD awards for the prior knee injuries in 1991 and 1994 were previously apportioned, although the restriction for each was the same and was entirely subsumed within the work restriction for the spine in the original award. Regarding the 1975 and 1987 injuries, defendant had admitted in its post-trial brief that the injured worker was medically rehabilitated from the disabling effects of the prior injury at the time of the subsequent injury, according to the law in effect at the time. Thus, under *Vargas*, apportionment of these prior injuries was not permissible.

Defendant contended that the WCJ lacked subject matter jurisdiction to award the increased PD because the petition to reopen was filed more than five years after the date of injury, contrary to Labor Code §§5410, 5803 and 5804. The Court disagreed and found that the defendant waived the statute of limitations by not raising the affirmative defense at trial. It rejected defendant's argument that it did not need to raise the timeliness of the petition to reopen or the lack of jurisdiction at trial because subject matter jurisdiction is not conferred by consent, waiver, or estoppel and may be raised even on appeal. However, the Court found that the petition to reopen was based on §5410, a statute of limitations; not §§5803 and 5804. Statutes of limitations are an affirmative defense which operates to bar the remedy and not to extinguish the right of the employee. Therefore, such a defense may be waived.

The WCJ had found no apportionment to the degenerative disease of the knees because the AME failed to distinguish between pathology arising prior to the original award which could not be apportioned under *Vargas*, and that arising after the original award issued. The Court seemed to have some doubts that the record did not contain substantial evidence of apportionment to pathology because the AME found that the increased PD occurred after the Joint F & A, although the pathology had been in existence prior to that event. However, considering the complexity of the case and the major recent changes of Senate Bill No. 899, the Court believed that the defendant should be afforded an opportunity to demonstrate whether the AME can provide substantial evidence of the increased knee disability caused by the degenerative disease of the knees after the joint findings and award.

Thus, the WCAB's decision was affirmed in part and annulled in part. The matter was remanded to determine apportionment of the increased knee disability by the degenerative disease of the knees that existed after the joint findings and award.

*Continental Casualty v. WCAB (Goodin) (4/24/09) WCC  
35172009 CA; 4<sup>th</sup> App. Dist. Not for publication*

Applicant was employed at a nursing home laundry facility, in which she was exposed to various fumes and chemicals from 1997 through October, 2002. Her symptoms began in 1998 and the medical file does not document any prior history of respiratory problems, even though she had a history of smoking. The only evidence concerning AOE/COE exposure and apportionment was an opinion from Dr. Levister that indicated applicant had a combination of personal, non-industrial causes due to smoking and allergies, as well as industrial exposure in an enclosed environment impacting her airways. He apportioned 60% to personal, non-industrial factors, and 40% to industrial causation.

The trial judge found applicant 100% disabled but found Dr. Levister's explanation was not adequate. Thus, the judge rejected the opinion on apportionment. The WCAB upheld the findings on reconsideration.

The appellate court annulled and remanded the matter to make findings consistent with the opinion. It noted that the only evidence about causation of disability came from Dr.

Levister, which noted both pre-existing and work-related factors caused the disability. The judge had an option to develop the record but could not ignore the only opinion on apportionment.

*Benson v. WCAB (2009) 74 CCC 113; 170 Cal. App. 4<sup>th</sup>  
1535 (1<sup>st</sup> App. Dist)*

Applicant worked as a file clerk starting in April 2002. Her job required repetitive neck and upper extremity motion and constant standing. On June 3, 2003, she sustained an injury to her neck when she reached over head pulling at a plastic bin. She sought treatment the next day when her pain did not subside. The original diagnosis was neck strain and she was placed on light duty work. By July, 2003, she was placed on TTD and eventually underwent a three level fusion of the C-spine. She filed one application for the specific injury.

Dr. Izzo examined her as an AME. He concluded she sustained the specific injury, as well as a CT injury through June 3, 2003. She became P&S for both injuries on September 26, 2005 and apportioned disability 50% to each incident.

After trial, the WCJ utilized the Wilkinson Doctrine and awarded the applicant 62% disability (\$67,016.25). Defendant filed for reconsideration and the WCAB held En Banc that the Wilkinson Doctrine is not consistent with the new laws of apportionment. The Board awarded two 31% awards (totaling \$49,210.00). Applicant appealed.

The First DCA affirmed. It cited the plain language of LC 4663 and LC 4664; the repeal of former LC 4750; the legislative history and deference to WCAB interpretation of WC statutes. The holding in Brodie was reiterated and it was found the Legislature intended to reverse old rules of apportionment.

**B. Labor Code §4664**

**XVI. Death Benefits**

**XVII. Hearings**

*Bontempo v. WCAB (4/30/09) \_\_\_ CA4th \_\_\_ (2<sup>nd</sup> App. Dist.)  
WCCC 3519009 CA*

Applicant was employed as a street maintenance worker for Alhambra and sustained a right knee injury following a fall of a city truck in March, 2003. While the claim was pending, he filed a claim for pulmonary injury. Applicant did not work after mid-2005 as the city had not mod/alt work. Under LC 4658(d)(2), permanent disability payments are to be increased by 15% if no offer of regular/mod/alt work is made within 60 days of termination of TTD.

Prior to trial, the parties stipulated the pulmonary condition was P&S and the city was paying an increase of 15% on the weekly benefits for that claim. The parties checked the boxes for “permanent disability” and “apportionment” on the PTC statement. The trial judge awarded a 50% PD for the knee at a rate of \$185/week and 37% PD award to the pulmonary injury at \$220/week. The judge did not apply the 15% increase to the pulmonary award.

Applicant filed a petition for reconsideration alleging he was entitled to the 15% increase on the pulmonary claim. The city opposed noting the increase was not raised as an issue at trial or on the MSC statement and no evidence was submitted on the issue.

The 2<sup>nd</sup> DCA noted the city had stipulated it was paying the IW a 15% increase. The court noted the MSC statement had boxes checked for permanent disability and apportionment which would constitute sufficient notice to the judge to consider LC 4658(d)(2) issues. The matter was remanded to recalculate the PD award starting after 60 days.

### **XVIII. Compromise and Release**

*Huhtamaki Americas, Inc. v. WCAB (Madhaw)* (2008) 73 CCC 1549, Court of Appeal, Third Appellate District, unpublished opinion.

Applicant settled her workers’ compensation case with her employer by agreeing to a lump sum payment of \$35,000, from which would be deducted \$10,260 subject to proof for PD advances through March 10, 2005, plus other deductions for an EDD lien and attorney fees. The balance of \$20,054.29 was to be paid to applicant “less further [PDAs] made after the date set forth above.” In an addendum to the C&R it was noted that applicant disputed receiving a PDA of \$2,880 that defendant claimed to have made, and it was agreed that defendant would withhold that amount “pending proof of receipt.”

After the agreement was signed, defendant claimed credit for additional PDAs totaling \$5,278 that were paid in July 2006. Applicant objected to the deduction, contending defendant was obligated to pay the entire balance of \$20,054.29, as shown on the C&R. Defendant disagreed, claiming it was entitled to credit for all PDAs “subject to proof,” including the \$5,278.

A trial was held and applicant testified she would not have settled her case for less than a lump sum payment of \$20,000. The WCJ ruled that the defendant was not entitled to deduct the additional sums, finding that the phrase “subject to proof” in the C&R was limited to the disputed \$2,880 PDA and did not include the \$5,278. He also found that since defendant had failed to have available a computer print-out of benefits paid, it could not unilaterally alter the terms of the agreement later by seeking credit for the additional PDAs. Defendant filed a petition for reconsideration which was denied. It then sought judicial review.

The Court noted that the issue was not the sufficiency of the evidence, but rather the interpretation of the contract. It found the language of the C & R to be as clear in supporting defendant's right to the credit as the WCAB found it to be clear in denying it. It agreed with the WCJ that the phrase "subject to proof" in the C&R was limited to the disputed \$2,880 PDA. However, the C&R explicitly provided that defendant was entitled to credit for future PDAs in the amount of \$5,278 if it could show those payments were made after March 10, 2005.

The fact that defendant failed to comply with the regulation requiring it to produce a current computer printout of benefits paid does not deprive defendant of its contractual right to get credit for the \$5,278 in PDAs made after March 10, 2005. The regulation does not include a sanction for noncompliance and applicant, who never disputed receipt of the \$5,278, was just as responsible for knowing what had been paid as the defendant. The Board's decision was therefore annulled, and the case remanded for further proceedings consistent with the Court's opinion.

#### **XIX. Findings and Awards and Orders**

*Los Angeles County Department of Parks and Recreation v. WCAB (Calvillo)*  
(2008) 73 CCC 798, Court of Appeal, Second Appellate District, Division  
Five, unpublished opinion.

Applicant was injured in September 1997. In September 1998, the parties entered into the following stipulation which was written into the minutes of hearing:

"[P]arties stipulate to earnings of \$396.16 per week resulting in a t.d. rate of \$264.10 per week. Defendants to pay any sums outstanding, at aforementioned rate, retroactive to date, and surgery recommended by the treating doctor."

In March 1999, after surgery was performed, the parties entered into another written stipulation as follows:

"The parties Stipulate that the applicant...is to be paid temporary Disability benefits at the rate of \$264.10/week based upon average weekly earnings of \$396.16. Defendants are to pay any sums outstanding, at the rate of \$264.10, retroactive to date.

At the bottom of the stipulation appeared the words, "It is so ordered," followed by the WCJ's signature.

In August 1999, the parties entered into a C & R that settled applicant's claim of penalty for unreasonable delay of TTD indemnity to date under Labor Code §5814. The parties also stipulated that the future rate of temporary total disability indemnity would be \$343.43 per week.

Applicant had further surgery in 2001 and was declared P & S by the treating physician in 2002 at which point defendant terminated TTD benefits. Thereafter, in 2005, the

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treating physician reported that applicant was again TTD and performed additional surgery. Defendant denied liability for further TTD.

The matter proceeded to trial on the issues of jurisdiction to award further TTD and penalty for unreasonable delay. The WCJ awarded TTD from the date of the surgery to the present and continuing. He also awarded a 25 percent increase under §5814, and attorney's fees under §5814.5. In the opinion on decision, the WCJ explained that jurisdiction existed because the March 1999, order was enforcement of the September 11, 1998, stipulation to average weekly earnings. Thus, there was no award of retroactive benefits, and a petition for continuing jurisdiction was not required under section 5410. In addition, the failure to pay TTD was unreasonable because the issue of jurisdiction was an after the fact excuse and there was no legal doubt of liability.

Defendant petitioned for reconsideration. The WCAB affirmed the WCJ's decision except for limiting the penalty under §5814 and deleting the attorney's fee under §5814.5. Defendant then sought judicial review, contending that the September 1999 stipulation followed by the March 1999 order and payment constituted an executed award. In the alternative it claimed that the WCAB lacked jurisdiction to award TTD that began more than five years from the date of injury without a petition for continuing jurisdiction.. It further contended that genuine legal doubt of liability existed and there was no unreasonable delay or refusal of benefits.

After reviewing the WCAB file, the Court of Appeal determined that the stipulations and March 1999 order provided for payment of the difference between the TD paid and the stipulated rate. The stipulations and order were only temporary or interim resolutions pending an award after trial. Therefore, a petition for continuing jurisdiction under Labor Code §§5410 and 5804 was not required, and the WCAB retained its original jurisdiction more than five years from the date of injury.

Regarding defendant's second contention, the WCAB had relied on the 1978 amendment to Labor Code §4656 which removed the pre-1978 limitation on TTD to 240 weeks within a five year period. However, the Court observed, this did not mean that an applicant could invoke the WCAB's jurisdiction to award TTD benefits whenever medical treatment was required. In *Nickelsberg v. WCAB* (1991) 56 CCC 496, the Supreme Court interpreted the 1978 amendment as authorizing TTD to extend beyond five years from the date of injury only when the period of TTD commences within five years from the date of injury and is continuous.

The Court affirmed WCAB's finding that the stipulations and order to comply was not a formal award. However, it reversed the Board's award of the new period of TTD more than five years from the date of injury, and therefore, the penalty award was also reversed. The matter was remanded for further proceedings consistent with the Court's opinion.

**XX. Reconsideration/Removal/WCJ Disqualification/Judicial Review**

*Burnham v. WCAB* (2008) 73 CCC 579, Court of Appeal, Third Appellate District, unpublished opinion.

Applicant sustained a cumulative trauma ending April 20, 2004, the day after SB 899 was enacted. She was evaluated by an AME who found 15 percent PD under the old PDRS, but no impairment under the new schedule. After a trial, the WCJ found that the new PDRS applied and awarded zero PD. Applicant filed a petition for reconsideration on August 14, 2006 that was granted on October 16, 2006. In this first order, the WCAB reversed the WCJ and found the old schedule should apply.

Defendant filed a petition for reconsideration from the Board's order on October 31, 2006. That petition was granted for further study on January 2, 2007 and the Board issued its decision after reconsideration on February 6, 2007. In the interim between the two dates, the Board decided *Pendergrass v. Duggan Plumbing* (2007) 72 CCC 95 (*Pendergrass I*). Thus, in its second decision, the Board affirmed its first decision in which it found the new PDRS to be applicable. Thereafter, on February 16, 2007, the WCJ issued a new decision, consistent with the orders of the WCAB, awarding 15 percent PD under the old PDRS.

Defendant filed a second petition for reconsideration on March 5, 2007 which was granted on May 7, 2007. In addition, it filed a petition for writ of review on March 21, 2007. This time, in the interim between the two dates, the WCAB rescinded its decision in *Pendergrass I* and issued a new en banc decision in the same case, *Pendergrass v. Duggan Plumbing* (2007) 72 CCC 456 (*Pendergrass II*). Therefore, the Board rescinded its second order and issued a third order, finding that the new PDRS applied and that applicant sustained no PD.

In the meantime, the Court of Appeal granted defendant's petition for writ of review on May 10, 2007 and dismissed it a week later at defendant's request. Applicant filed her petition for writ of review and the Court issued the writ.

Applicant contended that the WCAB's grant of reconsideration on May 10, 2007, was a null act because the City could not file a new petition for reconsideration and could only petition the Court of Appeal. She argued that defendant was first aggrieved in this matter by the Board's first order of October 16, 2006 and that no matter what happened after that point, defendant had exhausted its administrative remedies concerning this particular issue. Defendant disagreed, claiming that it was newly aggrieved after the WCJ issued her February 16, 2007 PD award. Prior to that time, there had been no decision concerning the nature and extent of PD.

The Court felt that neither argument was controlling and that under the Board's continuing jurisdiction over all its orders, decisions, and awards, it had the right to amend the order upon a showing of good cause. The good cause was the change in statutory interpretation reflected in *Pendergrass II*.

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The Court also addressed the underlying issue of whether applicant's PD should be calculated using the old PDRS or the new. Since by this time there were appellate decisions holding that the obligation to send a Labor Code §4061 notice arises with the last payment of TD and not the first, the Court was not persuaded by applicant's "attempts to revive the analysis set forth in *Pendergrass I* and abandoned in *Pendergrass II*." Thus, the WCAB's order was affirmed.

## **XXI. Reopening**

*Dykes v. WCAB* (2008) 73 CCC 1535, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant injured his back and received a stipulated award of 20.5 percent PD. He again injured his back while working for the same employer. A WCJ found that he was 73 percent permanently disabled. Applying new Labor Code §4664, the WCJ subtracted the dollar value of the prior award rather than the percentage of disability. Defendant filed a petition for reconsideration that was denied by the WCAB. The Court of Appeal granted defendant's petition for writ of review and sustained the WCAB in a published decision that became final when the Supreme Court declined to review it.

In subsequent cases concerning the same issue, two different appellate districts reached different conclusions. Therefore, the Supreme Court granted review and ultimately concluded in *Brodie v. Workers' Compensation Appeals Bd.* (2007) 72 CCC 565, that the Legislature did not intend to disturb the method of calculating apportionment set down in *Fuentes v. WCAB* (1976) 41 CCC 42, which required subtraction of the percentage of disability rather than the dollar value of the prior award.

In the meantime, prior to issuance of the Supreme Court's decision, defendant had timely filed a petition to reopen applicant's PD award for "good cause," citing a change of law due to a conflict in interpretation of Labor Code Sections 4663 and 4664 between the Courts of Appeal." The WCJ denied the petition to reopen, stating in her opinion that "[t]he prior decision in this matter is *res judicata* as to this case. The fact that in another case a different result was arrived at regarding the same issue does not change that fact." Defendant petitioned for reconsideration. The WCAB rescinded the WCJ's findings, granted defendant's petition to reopen, and remanded the matter back to the WCJ with instructions to recalculate applicant's PD award in a manner consistent with *Brodie*. Applicant then sought judicial review.

The Court observed that Pursuant to Labor Code §5803, the WCAB maintains the power to "rescind, alter, or amend any order, decision, or award" upon a showing of good cause. If sufficient evidence supports a finding of good cause, then the WCAB acted within its powers by reopening and reconsidering applicant's PD award.

Among other arguments that were rejected by the Court, applicant contended that permitting the WCAB to reopen a disability award based on a change in the law will cast doubt on all final WCAB awards and create "a recipe for mass relitigation," particularly

when future disability tables are revised. However, the Court observed that the Legislature had already alleviated his concern for the potential of mass relitigation by declaring that any future amendments shall only apply to injuries occurring *after* the effective date of the PDRS. Subsequent revisions to the PDRS therefore would not appear to constitute good cause to reopen prior PD awards.

Thus, the Court held that the Supreme Court's decision in *Brodie* constituted good cause to reopen applicant's prior disability award, even after it had been affirmed by the same Court and denied review by the Supreme Court, because defendant timely petitioned the WCAB within five years from the date of applicant's injury. Accordingly, applicant's petition for writ of review was denied.

*Priest v. WCAB* (2008) 73 CCC 1556, Court of Appeal, Fifth Appellate District, unpublished opinion.

In 1994, shortly after applicant commenced working for the employer as a gun salesperson, but before receiving her first paycheck, she was injured in an automobile accident. At a 1996 trial, she claimed average weekly earnings of \$507.70 and testified that she expected to earn \$1,800 per month plus \$200 for each weekend gun show. The WCJ awarded TD at the rate of \$338.17 per week based on an average weekly wage of \$507.70. Defendant filed a petition for reconsideration to which applicant answered that she carried her burden of proof establishing an average weekly wage of \$507.70 per week, based upon earnings of \$2,200.00 per month.

Twelve years later, in 2008, the question of applicant's earnings at the time of her 1994 accident again came before the same WCJ. In his opinion on decision, the WCJ admitted his math was "faulty" in determining applicant's TD. The WCJ recalculated that earnings of \$1,800 per month, times 12 months, divided by 52 weeks, plus \$200 per weekend gun show amounted to average weekly earnings of \$615, entitling her to TD of \$410.00 per week, instead of the \$338.17 previously awarded.

Defendant again petitioned for reconsideration to which applicant, now unrepresented by counsel, did not respond. The WCJ stated in his report that he recalled that applicant had raised the earnings issue "around 2000 or earlier." At that time, he noted that he had made an obvious math error, and he ordered the parties to adjust the issue. However, nothing apparently was done and in the meantime the file was destroyed so the order could not be found.

In a split decision, two WCAB commissioners voted to grant reconsideration. Reversing the WCJ's findings, the panel majority, found that its jurisdiction to reopen a decision for good cause lapsed in 1999, and the "WCJ's vague recollection 'that applicant raised the earnings issue around 2000 or earlier'" was not sufficient proof of the filing of a timely petition to reopen to provide jurisdiction for the Board to amend its decision. The dissenting commissioner would have denied reconsideration "[g]iven the uncertainty about the history of this case, the closeness in time between the deadline for reopening and the approximate time of applicant raising the issue, and the fact that the WCJ only

corrected a mathematical error ....” Applicant, in propria persona, then filed a petition for writ of review, asking the Court to follow the recommendation of the WCJ and dissenting commissioner.

The Court of Appeals noted that Labor Code §§5803 and 5804 provide that the WCAB has continuing jurisdiction over all its orders, decisions, and awards, but that no award of compensation shall be rescinded, altered, or amended after five years from the date of the injury except upon a petition by a party in interest filed within such five years. Thus, applicant had the burden of establishing that she filed a petition to reopen by 1999. While the WCJ referenced an order to adjust the earnings issue, “around 2000 or earlier,” he never stated that a timely petition to reopen had been filed.

The Court felt that by insisting that the evidence supported earnings of \$507.70 in the original proceedings in 1996, applicant had waived the issue. It also invoked the doctrine of invited error, under which a party is estopped from asserting prejudicial error where his own conduct caused or induced the commission of the wrong. Therefore, the Board was justified in rescinding the WCJ’s amended award and reinstating the finding that she was only entitled to a TD rate of \$338.17 per week. The petition for writ of review was denied.

## **XXII. Statute of Limitations**

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

Fourteen years after applicant’s retirement, he filed a claim of cumulative trauma to his heart. He later amended the claim to include skin and prostate cancer. The WCJ found the case to be compensable, rejecting defendant’s statute of limitations defense since there was no evidence that applicant was aware of his injuries prior to the filing of the claim. After defendant’s petition for reconsideration was denied, defendant sought judicial review.

Defendant contended that applicant’s claim of industrial injury to his heart and skin cancer was barred pursuant to Labor Code §§5404 and 5412. It further argued that substantial evidence did not support the finding that applicant’s prostate cancer was industrially caused. The Court noted that the date of injury in cumulative trauma cases is that date upon which the employee first suffered disability and either knew, or in the exercise of reasonable diligence should have known, that the disability was caused by his employment. (Labor Code §5412). Although applicant began experiencing chest pains in the early 1990’s and even had a stress echocardiogram in 1992, it was not until 2003 that he was diagnosed with coronary heart disease. Thus, his claim filed a few months thereafter was not time barred.

The WCJ relied on applicant’s testimony that no one had ever told him his skin cancer was related to his employment prior to filing his claim. However, even assuming this to be true, the Court concluded that he knew or reasonably should have known of the

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connection. Applicant had a 30-year history of skin problems due to sun exposure and had been receiving medical treatment and advice during this time. He obviously knew the connection between exposure to the sun and his skin problems since he took preventative measures. Furthermore, he knew he was exposed to the sun in his work. Therefore, the Court found that defendant did establish the statute of limitations defense with regard to applicant's skin cancer claim.

Defendant also contended that the Board's finding that applicant's prostate cancer was related to his on-the-job exposure to toxic chemicals was based on speculative and conclusory evidence. Defendant's QME, Dr. Green, opined that prostate cancer is not related to chemical exposure. However, applicant's QME cited studies that have found a link between cadmium exposure and an increased risk of prostate cancer. Applicant established that he was exposed to cadmium in his employment. Therefore, the opinion of the QME could not be dismissed as based on surmise, speculation or conjecture and the WCAB was entitled to rely on it, even if it was inconsistent with other medical opinions. The Board's order was annulled and the matter was remanded for further proceedings consistent with the Court's opinion.

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

In 1996, applicant sustained an industrial injury for which he filed a workers' compensation claim and received TD payments. In 1997, he injured his back after arriving at work two hours early. Although he reported the injury, the employer neither advised him of his potential eligibility for workers' compensation, nor furnished him with a claim form. In 1999, he retained an attorney who filed an Application for the 1996 injury, but did not file a claim for the 1997 injury. At the August 2002 trial of the 1996 injury case, the WCJ placed the matter off calendar to allow applicant to file a claim for the 1997 injury, but he didn't file an Application until March 2004. CIGA raised the one-year statute of limitations as a defense.

In 2004, both matters were consolidated and went to trial. Applicant testified that when he injured his back in 1997, he reported the injury to his supervisor and also to the employer's workers' compensation manager. He was not given a claim form and because he was given a "hard time" about coming to work early, he went to his own doctor for treatment. The employer never advised him of his right to file a workers' compensation claim. An AME report from 2001 stated that applicant had injured his back in 1997 and reported the injury to his employer. A notation on the signature page of the report indicated that a copy of the AME report was sent to applicant's attorney. As early as 1999, the treating physician sent a report to counsel in which he related the circumstances of the 1997 injury.

The WCJ found that the claim was not barred by the statute of limitations, but vacated his decision and conducted further proceedings after CIGA filed a petition for reconsideration. CIGA again sought reconsideration from the amended F & A, which was granted. Finding the record inadequate to allow meaningful review, the Board rescinded

the F & A, and returned the matter for further proceedings. After considering additional evidence, the WCJ again rejected CIGA's statute of limitations defense and found that statute was tolled by the failure of the employer, insurer or CIGA to notify applicant of his right to claim benefits. The WCJ also concluded that CIGA was estopped from asserting the statute of limitations by its failure to admit coverage for the 1997 injury until May 2003 which delayed applicant's filing of the Application. After the WCAB denied CIGA's petition for reconsideration, CIGA filed a petition for writ of review.

CIGA contended that any such tolling in this case ended when applicant acquired actual knowledge of his rights more than a year before he filed his claim. The Court noted that it was CIGA's burden to prove when applicant gained actual knowledge of his workers' compensation rights, and to carry its burden, CIGA was required to overcome a rebuttable presumption that applicant was ignorant of those rights. There was no substantial evidence that applicant was actually aware that the 1997 injury was potentially compensable as an industrial injury since it was sustained prior to the commencement of his shift. The request by counsel at the 2002 hearing for time to file an Application concerning the 1997 injury showed counsel's belief that the injury might be compensable but did not demonstrate actual knowledge on the part of applicant.

The fact that he retained an attorney to represent him in the prior claim did not establish actual knowledge, either. The attorney's knowledge cannot be imputed to the client. Nor does the content of the medical reports show actual knowledge on the part of applicant since there was no evidence that applicant read them.

CIGA additionally contended that the estoppel finding was unsupported by substantial evidence because the record failed to mention evidence of reliance by applicant upon any representation by CIGA, or other fact showing that CIGA's failure to timely admit coverage misled applicant or his attorney to his detriment. However, the Court noted that the party challenging the sufficiency of the evidence must raise any specific deficiencies in its petition for reconsideration which CIGA failed to do. Therefore, the decision of the Board was affirmed.

*The Earthgrains Company v. WCAB (Hansen)* (2008) 73 CCC 1000, Court of Appeal, Fifth Appellate District, unpublished opinion.

Applicant retired in June 2002 because he was about to undergo a spinal fusion and his doctor told him he would no longer be able to perform his job duties which required kneeling, squatting, stooping, bending, and lifting. In May 2005, he retained counsel and filed an Application alleging a cumulative trauma to his knees and spine. Defendant paid for the surgery pursuant to a prior stipulated award for which applicant had not been represented by counsel.

The WCJ found that applicant's claim was timely, that he sustained a work-related cumulative trauma injury through his last date of employment in 2005, and that defendant owed TD from June 2004, to August 2006. The WCJ also awarded 49 percent PD after apportionment for three prior injuries. The WCJ expressly found the reporting of applicant's QME to be more persuasive than that of the defense QME.

Defendant petitioned for reconsideration and the WCJ amended the F & A, finding that applicant was entitled to TD beginning in June 2002, not June 2004. The WCJ also amended the date of injury for the cumulative trauma injury to indicate that it occurred in May 2005, on or before the date that the Application was filed, which was “the date upon which there was a concurrence of disability and knowledge by [applicant] that such disability was caused by his prior employment, within the meaning of LC 5412.” The WCAB thereafter summarily denied the petition for reconsideration based on the reasoning set forth in the WCJ’s Report and Recommendation. Defendant then filed a petition for writ of review.

Defendant contended that since applicant underwent knee replacement surgery in 2002, he should have known he sustained a new cumulative trauma injury to his knee at that time. However, defendant did not point to any specific testimony or medical records demonstrating that applicant knew or should have known his additional knee complaints were work related. A 2001 report prepared by a nurse practitioner, suggesting applicant sustained a new cumulative trauma injury was sent to the insurance carrier, but never to applicant. Furthermore, applicant testified that he had never heard the term “cumulative trauma” before going to his attorney’s office in 2005.

Defendant further claimed that it had no knowledge of applicant’s medical condition. However, in claiming that certain key reports should have led applicant to believe he had sustained a cumulative trauma, the carrier had a responsibility to provide applicant with a claim form on behalf of the employer. The failure of the carrier to acknowledge that it was paying for treatment stemming from a new cumulative trauma injury or injuries not covered by the prior awards undermines its own argument that applicant similarly should have known.

Defendant additionally contended that substantial evidence did not support the WCAB’s findings of fact as to TD, apportionment, and the permanent and stationary date and that the record instead should be more fully developed. The Court rejected defendant’s argument that applicant was not entitled to TD as a result of his voluntary retirement from the labor market. His uncontroverted testimony established that his retirement “was necessitated because of his industrial injuries and related surgical procedures.”

The Court likewise rejected defendant’s claim of additional apportionment to age, weight, a high school football injury, and pre-existing spondylolisthesis, noting that neither QME found a basis for apportionment other than to the prior awards. Defendant’s complaint concerning the P & S date, appeared to have merit, however. The WCJ had relied on applicant’s QME who had not specified a P & S date in his report. The Court was unable to determine the basis for the P & S date found by the WCJ. Therefore, it annulled the WCAB’s decision only as to the P & S date and remanded the matter to the WCAB to reconsider and set forth in detail the reasons for its decision.

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*Pugh v. WCAB* (2008) 73 CCC 1561, Court of Appeal, Second Appellate District, Division One, unpublished opinion.

In 1997, applicant's doctor diagnosed her as suffering from stress that was work-related. He referred her to a psychiatrist who confirmed the diagnosis of stress and also found it to be work related. The first psychiatrist referred her to a second one with whom she started treating and this doctor also told applicant that her stress was connected to her job. In July 1999, applicant took a medical leave of absence from her job and never returned to work. She was granted disability retirement in 2005.

In the meantime, applicant filed an Application for Adjudication in August 2003 alleging cumulative psychological and physical injuries through her last day of work in 1999. The County rejected the claim on the ground, among others, that she failed to file her claim within one year from the date of injury.

At trial, applicant testified that although all of the doctors she consulted diagnosed her stress as job-related, none of them suggested that she consider filing a workers' compensation claim. She never told anyone at work that a doctor said she was suffering from work-related stress. She further testified that she never saw any signs posted at the facility where she worked advising employees of their workers' compensation rights. She testified that she waited until 2003 to file a claim because she was previously unaware of her rights.

Defendant produced no evidence that it posted a notice of workers' compensation rights at the workplace, nor did it produce any evidence that it provided applicant with an individual notice of her rights. The WCJ found that applicant's claim was not barred by the statute of limitations because of the failure to post the requisite notice. Defendant then sought reconsideration. The WCAB granted the petition and overruled the WCJ's decision on the statute of limitations issue, concluding that applicant knew in 1998, or at the latest 1999, that her stress was work-related and such knowledge was sufficient to trigger the one-year period for filing a claim under Labor Sections §§5405 and 5412. Applicant then filed a petition for writ of review.

The Court first noted that pursuant to Labor Code §3550, every employer subject to the workers' compensation law is required to post a notice advising employees of their rights under that law. The notice must be posted "in a conspicuous location frequented by employees" and must include the existence of time limits for the employer to be notified of an occupational injury. Noncompliance carries both criminal and civil penalties. Applicant contended that an employer who fails to post the notice required by section §3550 should also be precluded from raising the statute of limitations as a defense to an employee's claim for benefits.

The Court cited the case of *Reynolds v. WCAB*. (1974) 39 CCC 182, in which the Supreme Court held that because the employer was obligated to give certain notices prescribed by the administrative rules and failed to do so, it was not allowed to raise the technical defense of the statute of limitations to defeat petitioner's claim." Defendant

claimed that the facts were distinguishable in that in *Reynolds*, the applicant was unaware that his heart attack might be related to his job but the employer undoubtedly had the experience to recognize the connection. In contrast, here the applicant knew her injury was work-related and the defendant had no way of recognizing the connection.

The Court disagreed, pointing out that the notice that defendant failed to post informs the employee, among other things, that “[w]orkers’ compensation covers most *work-related* physical or *mental injuries and illnesses*,” and that the employee should “[r]eport the injury immediately” because “[t]here are time limits” and “[i]f you wait too long you may lose your right to benefits.” The Court also cited a case from the state of Missouri in which it was held that an employer who fails to post a substantially similar notice may not assert the statute of limitations to bar the claim. Defendant’s additional argument that the civil and criminal penalties contained in the statute should be deemed the only consequences for an employer’s failure to post the required notice was rejected for lack of any legal authority to support it.

The Appeal Board’s decision was annulled and the cause remanded for further proceedings consistent with the Court’s opinion.

**XXIII. Contribution**

**XXIV. Subrogation/Third Party Actions**

**XXV. Credit/Restitution/Fraud**

**XXVI. Special Benefits**

**XXVII. Penalties/Sanctions/Contempt**

**A. Labor Code §§ 5814 and 5814.5**

*Ramirez v. Drive Financial Services* (2008) 73 CCC 1324, Appeals Board en banc decision.

Pursuant to a C & R, defendant agreed to pay to pay applicant \$57,000 plus an additional \$3,000 as settlement of prospective vocational rehabilitation services. Under the terms of the C & R, all penalty issues were waived if defendant made payment within 30 days of service of the order approving. Defendant made payment five days late and applicant wrote letters to defendant, requesting a 25 percent penalty. Defendant then voluntarily paid penalties of \$5,700 and \$300, without withholding sums for attorney fees.

Applicant then filed a penalty petition, essentially asserting that defendant should have paid the maximum penalties available or each of the delays, which would amount to the maximum \$10,000 against the delayed \$57,000 payment and \$750 against the delayed

\$3,000 payment. In addition, applicant asserted that, because defendant underpaid the penalties, additional 25 percent penalties, plus interest, were owing. Finally, applicant requested attorney's fees pursuant to Labor Code §5814.5.

The WCJ issued his F & O, finding that no further penalties were owed for the late payments on the basis that a ten percent penalty was sufficient to accomplish a fair balance and substantial justice between the parties. However, he found that a ten percent (\$600) fee for applicant's attorney was warranted. The WCJ denied the claim for a fee pursuant to §5814.5, reasoning that section 5814.5, as amended to apply to all employers except the State, applies only to dates of injury on or after January 1, 2003, the effective date of the amendment. Applicant filed a petition for reconsideration.

The Board set forth a number of factors that a WCJ might consider in determining the amount of a §5814.5 penalty. The overriding consideration should be whether the penalty imposed would serve "the purposes sought to be accomplished" by §5814.5. The Board then went on to list additional factors that also might be considered in determining an appropriate penalty.

Because the WCJ offered no explanation as to why he thought the \$5,700 and \$300 penalties paid by defendant were the appropriate amounts, the Board rescinded the decision and returned the matter to the WCJ to consider this question in light of the Board's discussion above and, in a new decision, explain the reasons for his penalty determination.

Regarding applicant's claim for multiple penalties, the Board cited the Supreme Court's opinion in *Christian v. WCAB* (1997) 62 CCC 576 that multiple penalties may be assessed against a defendant "when the unreasonable delay or refusal of [the] benefits [due] is attributable to separate and distinct acts by an employer or insurance carrier." The Board commented to find multiple penalties in this case could lead to the anomalous result that a defendant would be in a worse position if, without an order from the WCAB, it pays *some* penalty than if it pays *no* penalty. However, the issue was remanded to the WCJ to decide it in the first instance.

Lastly, the Board addressed the issue of whether Labor Code §5814.5 may be applied to injuries occurring before its January 1, 2003 effective date. It concluded that an award of fees, pursuant to §5814.5, under these circumstances, would *not* constitute retrospective application of the amended statute. While applicant's date of injury predated the amendment of §5814.5, the liability created by amended §5814.5 did not arise by virtue of the injury. It arose because defendant unreasonably delayed payment of an award of compensation, an event that occurred after the 2003 effective date.

Having determined that applicant's attorney is entitled to a fee pursuant to §5814.5, the Board turned to how that fee should be computed. The Board concluded that such fees are to be based on a reasonable hourly rate and are to be awarded "in addition to" the increase awarded the applicant under section 5814(a), not as a percentage of applicant's increase. Nonetheless, the Board emphasized that if there is no prior award, or no

unreasonable delay, §5814.5 fees shall not be awarded. Moreover, §5814.5 fees should be allowed only for legal services rendered in “enforcing” the unreasonably delayed prior award, and not for any other purpose. In this case, the WCJ should determine the amount of the fee in a new decision.

Note: A petition for writ of review filed in *Ramirez* was denied on December 18, 2008.

**B. Labor Code § 5813**

*Duncan v. WCAB (Silva)* (2008) 73 CCC 1197, Court of Appeal, Third Appellate District.

The injured employee was killed in an industrial accident while working for an employer that was illegally uninsured for workers’ compensation liability. The Uninsured Employees Benefit Trust Fund (UEBTF) was therefore joined as a party defendant regarding the claim filed by his spouse and son. Applicants and the UEBTF agreed to an award of death benefits. Three months passed without payment of applicants’ attorney’s fees. Counsel then contacted the UEBTF on no less than five occasions without success and finally filed a petition for penalties and interest. The UEBTF finally issued a check four months after the award but declined to pay penalties and interest on the ground that such a payment is prohibited by Labor Code §3716.2.

Applicants’ attorney filed an amended petition for sanctions pursuant to §5813 and attorney fees pursuant to §5814.5 for the Fund’s delay in payment of the attorney fees. Finding that the UEBTF’s failure to make the attorney fee payment after repeated contacts constituted “bad faith action under Labor Code §5813, and that a sanction against the UEBTF for bad faith action is not prohibited by §3716.2, the WCJ ordered the UEBTF to pay a sanction of \$100 and deferred the issue of attorney fees.

The UEBTF filed a petition for reconsideration, asserting that the Supreme Court’s decision in *Dubois v. WCAB* (1993) 58 CCC 286, which holds that Labor Code §3716.2 which precludes an award of penalties against the UEBTF, applies equally to sanctions. Granting the petition, the WCAB concluded that a “sanction” under §5813 is different than a “penalty” imposed pursuant to §5814, and because §3716.2 states only that the UEBTF is not liable for “any penalties,” it does not preclude an award of “sanctions” pursuant to §5813. Accordingly, the Board held that the UEBTF “may be sanctioned, like any other party.” Nevertheless, it returned the matter to the WCJ for further development of the record to determine the reason for the delayed payment of attorney’s fees, and to consider whether the failure to comply with the award of attorney’s fees resulted from willful or bad faith actions, or from mistake, inadvertence, surprise, or excusable neglect. The UEBTF requested a writ of review which the Court of Appeal granted.

Even though the matter had been returned to the WCJ for further proceedings and decision, the Court felt that the Board’s decision was final for the purpose of judicial

review because the ruling that the statutory scheme permits such sanctions against the UEBTF settled an issue critical to the claim for benefits.

The Court noted that the penalty provisions of §5814 were “enacted as an inducement to prompt payment on the part of private employers and their insurers, which otherwise would have an economic incentive to delay or deny the payment of workers’ compensation benefits.” On the other hand, the sanction provision of §5813 is designed to protect against litigation abuses, not to remedy or penalize delayed payments of awards.

A similar statute, Code of Civil Procedure §128.5, has been judicially interpreted as authorizing “a sanction to control improper resort to the judicial process. Where legislation on an analogous subject uses identical or substantially similar language, the Court may presume that the Legislature intended the same construction, unless a contrary intent clearly appears. Therefore, the Court was required to presume that §5813 was enacted to give WCJs and the WCAB sanctions power to help them manage their calendars and provide for the expeditious processing of workers’ compensation cases, rather than to penalize delayed payments of awards.

The Court went on to note that in both common and legal usage, the words ‘sanction’ and ‘penalty’ are synonyms, to be used interchangeably. Thus, it found that sanction is not a workers’ compensation “benefit” within the meaning of section 3716.2. Additionally, the UEBTF has no economic incentive to engage in litigation abuses and sanctions would deplete the limited resources of the UEBTF. Therefore, the Court found that the WCAB erred in holding that sanctions can be imposed against the UEBTF; remanded the case for further proceedings consistent with its opinion; and required applicant’s attorney to reimburse the UEBTF for its costs on review.

## **XXVII. Attorneys/Attorney Fees**

*In Re the Matter of Ramon B. Pellicer* (2008) 73 CCC 1065, Appeals Board en banc decision.

Petitioner, an attorney, was suspended and placed on involuntary inactive enrollment from the practice of law by the State Bar pending finality of its recommendation of discipline to the California Supreme Court. A month later, he petitioned the WCAB for permission to appear as a hearing representative/non-attorney pursuant to Title 8, CCR §10779 which provides that “defrocked” attorneys shall be deemed unfit to appear as a representative of any party before the WCAB, but they may file a petition for permission to appear, a copy of which must be served on the State Bar.

The State Bar filed a Position Statement on the petition to which was attached as exhibits the State Bar Court’s Order of Entry of Default for failure to appear at the hearing and the Order of Involuntary Inactive Enrollment. Another exhibit, Notice of Disciplinary Charges contained twelve counts involving violations of the Rules of Professional Conduct. Reciting various reasons, the State Bar requested that the WCAB issue an order

denying petitioner's request and prohibiting petitioner from appearing as a non-attorney/hearing representative.

The Bar cited a similar case in which a former attorney who had resigned with charges pending began representing parties in administrative hearings, contending that if laypersons could undertake such representation, it must not constitute the practice of law. The Court held of Appeal that representation of parties before state administrative hearings does constitute the practice of law, "from which defrocked attorneys are categorically barred."

In a prior Significant Panel Decision of *In The Matter of John H. Hoffman Jr.* (2006) 71 CCC 609 concluded that both Rule 10779 and the State Bar Act preclude "defrocked" attorneys from appearing as a representative of any party before the WCAB, including lien claimants, and this preclusion extends to any activity that would constitute the practice of law."

After reviewing the request for permission to appear and the State Bar's response, and in view of the cited cases, the WCAB was persuaded that a "defrocked" attorney cannot be permitted to appear in workers' compensation proceedings.

Note: Although Rule 10779 allows the filing of a petition for permission to appear, this decision makes it difficult to understand how there would be any circumstances under which such a petition would be granted.

*Sutter Memorial Hospital v. WCAB (Chaidez)* (2008) 73 CCC 1569, Court of Appeal, Third Appellate District, unpublished opinion.

The parties stipulated that applicant was 100 percent permanently disabled as a result of her industrial back injury. Applicant's attorneys were awarded a fee of \$69,134. Defendant filed a timely petition to reopen to reduce the PD award which was granted based on the revised opinion of the AME after he viewed subrosa films taken of the applicant. As a result, applicant's award was reduced to 41 percent PD.

Defendant also sought restitution from applicant for overpayment of PD, and from applicant's attorneys for that portion of the fee that defendant believed was excessive. The WCJ ordered applicant to make restitution in the amount of \$60,092.45, but denied restitution against the attorneys, specifically finding that the law firm did not participate in the misrepresentation which led to overpayment. Defendant petitioned for reconsideration which was denied by the WCAB.

Applicant's attorneys contended that defendant's claim against them was barred because defendant failed to seek restitution within five years of the date of injury. The Court of Appeal rejected that argument on the ground that the WCAB's jurisdiction to enforce an award extends beyond Labor Code §5804's five-year limitations period. In its petition for

restitution, defendant asked the WCJ to enforce the reduction of PD through restitution of the alleged overpayment to both the applicant and her attorneys.

Regarding the restitution issue, the Court noted that defendant stipulated, as part of the original workers' compensation proceedings, that the \$69,134 awarded to applicant's attorneys was the reasonable value of legal services rendered to the applicant. Restitution is an equitable remedy which has primarily been utilized by courts to prevent unjust enrichment. Although the attorneys were "enriched" by the payment of attorney fees, they were not "unjustly enriched" because they did not participate in applicant's misrepresentation and received the fees in good faith. There was therefore no legal basis for restitution of the fees and the decision of the WCAB was affirmed.

*Smith v. WCAB; Amar v. WCAB (5/11/09) \_\_\_ Cal. 4<sup>th</sup> \_\_\_;*  
*WCC 35202009 CA*

Smith - Applicant sustained a CT injury to his right shoulder, neck, and psyche. The stipulations with request for award included future medical treatment. Eight years after the award, SCIF refused to authorize an epidural injection to Smith's back. An AME concluded the back pain resulted from the work-related injuries. SCIF authorized the injections without a formal hearing. Smith's attorney requested a fee, which was denied by both a WCJ and the WCAB.

Amar – Applicant sustained a right foot injury and obtained a stipulated award including future medical benefits. SCIF refused to authorize a weight loss program and treatment for non-industrial diabetes. The WCAB found the weight loss program was medically necessary to relieve the effects of the foot injury. Applicant's counsel sought a fee for services, which was denied by the WCJ and the WCAB.

The Supreme Court reversed the judgment of the Court of Appeal and held that the language of LC 4607 is unambiguous. The court held that challenging a specific treatment is not the same as challenging the continuing necessity for future medical treatment. Thus, LC 4607 does not permit an attorney fee award to IWs who successfully challenge UR denials of medical treatment.

## **XXIX. Civil Actions**

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