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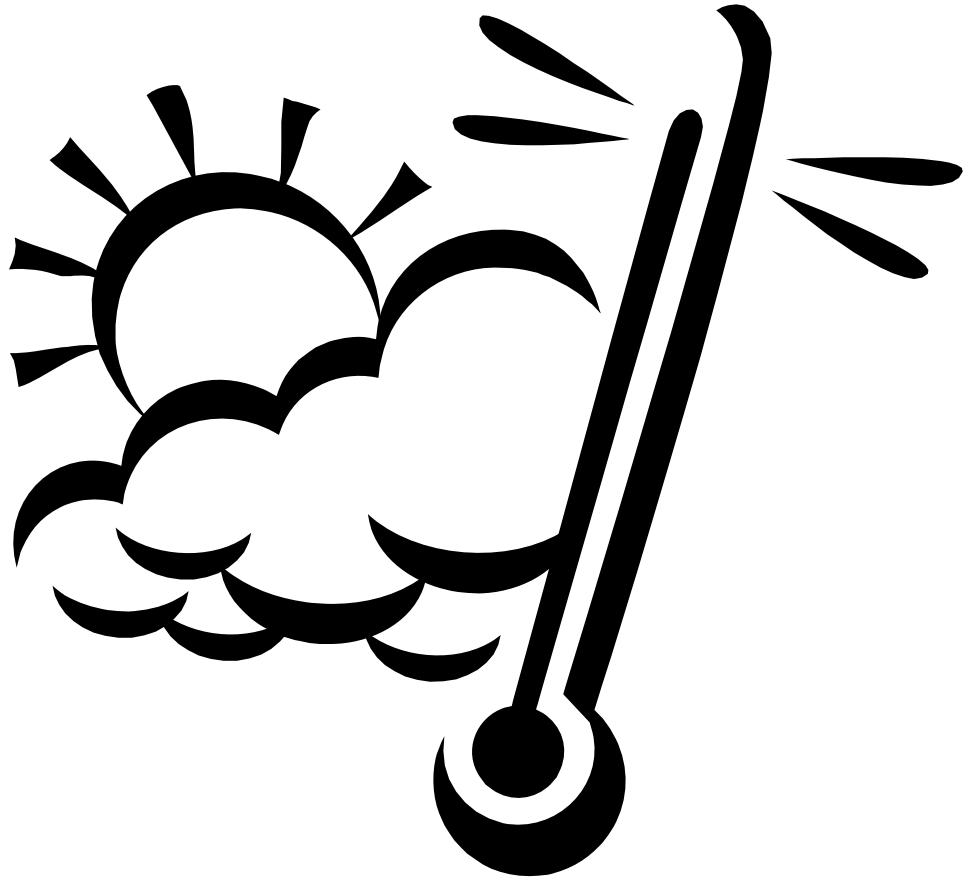
SAN FRANCISCO

SAN JOSE

SANTA ROSA

STOCKTON

VAN NUYS



PRESENTED BY

MULLEN & FILIPPI, LLP
AUGUST 2011

ONTARIO . COSTA MESA . OAKLAND . CONCORD . SACRAMENTO

**FIRST DISTRICT COURT OF APPEAL REJECTS WCAB'S FORMULA
FOR REBUTTING DFEC COMPONENT OF THE 2005 PERMANENT
DISABILITY RATING SCHEDULE**

Ogilvie vs. WCAB; _____ CA4th _____ (July 29, 2011)

Applicant was injured during the course of her work as a bus driver for the San Francisco Muni. Using a strict AMA Guides Rating under the 2005 Permanent Disability Rating Schedule (PDRS), applicant's injury resulted in 28% permanent disability. However, applicant argued that the rating did not accurately reflect the true extent of her disability because it did not adequately consider her loss of earning capacity. (Both applicant and defendant retained vocational rehabilitation experts who estimated the loss of earning capacity somewhere between 51% and 53%.)

The Workers' Compensation Judge agreed that the scheduled rating did not adequately compensate the applicant. Therefore, he found that the applicant had rebutted the 2005 PDRS. The Workers' Compensation Judge awarded 40% permanent disability. The City petitioned for reconsideration.

The Workers' Compensation Appeals Board granted reconsideration and issued an en banc decision in which it set out a formula that it believed was "based on empirical data and findings" as required by Labor Code §4660. (The formula involved comparison of the applicant's actual lost earnings with the wages of similarly situated non-injured workers.)

Both the City and Ogilvie sought review. The City alleging it was error to allow applicant to challenge the DFEC component of the schedule and Ogilvie arguing that not only should she be allowed to challenge the DFEC, but the overall final permanent disability rating, as well.

The First District Court of Appeal granted the petition and held that the WCAB overstepped its authority in devising a new formula for calculating DFEC.

However, the Court stated that because the 2005 PDRS is considered "prima facie evidence" of an employee's permanent disability, the schedule may be rebutted. It then discussed three possible methods of rebuttal:

1. The applicant may show a factual error in the application of the schedule (e.g. improper inclusion or exclusion of a factor of disability when applying the formula);

2. The applicant may challenge the data underlying the DFEC adjustment factors formulated by the RAND Institute. (As an example, the Court notes that there was no direct link between the injury data used by RAND and the AMA Guides.)
3. The Court also found that an applicant can show that an injury has impaired his or her rehabilitation, such that the future earning capacity is diminished beyond what is reflected by the schedule. (This is essentially an application of LeBoeuf to show that the permanent disability rating is inadequate.)

The matter was remanded to the WCAB for further development of the record consistent with these methods.

**COST OF LIVING ADJUSTMENTS (COLA) TO PERMANENT TOTAL
DISABILITY OR LIFE PENSIONS APPLY ON THE JANUARY 1ST
AFTER THE INJURED WORKER FIRST BECOMES ENTITLED TO
AND RECEIVES SUCH BENEFIT**

Baker v. WCAB and X.S. (2011) Aug. 11 CA1/6 H034040

- 1) In those cases wherein the injured worker is 100% disabled, the cost of living adjustment (COLA) would apply on the January 1st after such worker was deemed permanent and stationary;
- 2) In such cases wherein the injured worker is awarded permanent disability and a life pension, such worker is entitled to receive the cost of living adjustment (COLA) on the January 1st after the permanent disability is exhausted and the life pension begins.

**TREATMENT OUTSIDE THE MPN IS NOT PERMITTED UNLESS THE
EMPLOYEE HAS PRE-DESIGNATED A PRIMARY TREATING
PHYSICIAN**

Scudder vs. Verizon California, Inc. (ADJ 916063) (March 10, 2011)

Applicant was employed as a cable splicer for defendant Verizon when he sustained injury to his left knee, low back and also suffered from deep vein thrombosis on February 14, 2006.

Verizon had established a medical provider network (MPN). However, the applicant had pre-designated a treating physician (Dr. Feldman) pursuant to Labor Code §4600(d). Therefore, he was not required to treat within the MPN.

Dr. Feldman referred the applicant to a Dr. Johnson (non-MPN doctor), who then referred the applicant to two additional specialists (non-MPN doctors).

The applicant (who was initially unrepresented) was also evaluated by a Panel QME. Following the PQME evaluation, applicant retained counsel and his new attorney designated Dr. Sobel as the primary treating physician. Dr. Sobel referred the applicant to Dr. Lipper.

At the trial, defendant challenged the admissibility of the reports from Drs. Sobel and Lipper.

The Workers' Compensation Judge issued an Award in favor of the applicant, and the Opinion on Decision stated that the Award was based on the reports of Drs. Sobel and Lipper.

Defendant sought reconsideration, contending that only a pre-designated physician can refer an injured worker to another physician outside the MPN.

A Board Panel granted reconsideration. The Panel noted that under Rule 9780.1(c), an employee may treat outside an MPN if he or she had validly pre-designated a treating physician. Pursuant to Rule 9780.1(d), a referral by the pre-designated physician need not be within the MPN. Therefore, the initial treatment by Dr. Feldman was valid, as were Dr. Feldman's referrals to Dr. Johnson and the other non-MPN physicians.

However, because Dr. Sobel was not a pre-designated physician or on the MPN, his treatment was not authorized, nor was his referral to Dr. Lipper. Therefore, their reports were inadmissible.

Scudder vs. Verizon California, Inc.

The matter was remanded with instructions to the Workers' Compensation Judge to determine permanent disability without reliance on the inadmissible reports.

NOTE: Under the recent holding in Valdez vs. Warehouse Demo Services, the defendant should not be responsible for the cost of the treatment or reports by the unauthorized, non-MPN physicians.

**IF EMPLOYEE TREATS OUTSIDE A VALID MPN, REPORTS FROM
THE NON-MPN PHYSICIAN ARE INADMISSIBLE AND DEFENDANT IS
NOT RESPONSIBLE FOR THE COSTS OF THE REPORT OR THE
TREATMENT**

Elayne Valdez vs. Warehouse Demo Services 76 CCC 330
(April 20, 2011; en banc)

Applicant filed a claim for industrial injury occurring on October 7, 2009 to her back, right hip, neck, right ankle, right foot, right lower extremity, lumbar spine and bilateral knees while employed as a demonstrator for the defendant.

Defendant accepted the claim and the applicant was properly notified of the employer's Medical Provider Network (MPN). She initially treated with a physician from the MPN from October 9, 2009 to October 31, 2009. Thereafter, she began treating with a non-MPN physician to whom she was referred by her attorney.

The matter went to trial on July 22, 2010 on the issues of temporary disability and attorneys fees. Applicant relied on reports from the non-MPN physician in support of her claim for temporary disability. Defendant objected to the reports. The Workers' Compensation Judge overruled the objection, admitted the reports and, in reliance on the physician's findings, awarded applicant temporary disability benefits for the period November 2, 2009 through February 10, 2010.

Defendant petitioned for reconsideration, contending that the reports of the non-MPN physician were inadmissible and that the defendant was not liable for the cost of the non-MPN treatment and reports. (Significantly, the applicant did not file an Answer to the Petition for Reconsideration.)

In its en banc decision, the WCAB discussed the Labor Code Sections which allowed the establishment of MPNs and the notice requirements which a defendant must meet. When the defendant complies with all of the requirements, if an applicant seeks treatment outside the MPN, the non-MPN physician cannot be the primary treating physician and the reports from that physician are inadmissible. Further, citing Labor Code §4605 (“[n]othing contained in this chapter shall limit the right of the employee to provide, *at his own expense*, a consulting or any attending physician whom he desires [emphasis supplied]”), the Board found that the defendant is not responsible for payment for either the treatment obtained outside the MPN or the reports of the non-MPN physician.

Applicant's attorney has now filed his own Petition for Reconsideration which is currently pending before the WCAB. Should that petition be denied, it is likely that applicant will petition for a Writ of Review in the Second District Court of Appeal.

In addition, counsel for the applicant in a separate case (*Saldivar vs. AJB Ranch*) has filed his own Petition for Reconsideration in the *Valdez* case alleging that the Commissioners improperly "assume" that the defendant in *Valdez* had established and properly noticed its MPN.

**ALMARAZ/GUZMAN MAY BE USED TO
DECREASE WHOLE PERSON IMPAIRMENT**

Riley vs. City of Pasadena 39 CWCR 117 (2011)

Applicant injured her right knee and claimed by compensable consequence an injury to the left knee, during the course of her employment as a Police Officer with the City of Pasadena. The parties selected an Agreed Medical Examiner to evaluate the applicant's injury under the AMA Guides. The doctor found injury to both knees with impairment assessed at 37%.

The left knee injury remained in dispute in light of no contemporaneous medical evidence to support left knee symptoms following the right knee injury; applicant's longstanding history of left knee injuries prior to this claim; prior recommendations for a left knee replacement pre-dating the subject injury; applicant's ability to perform all of her job duties without restrictions; and, applicant's own testimony of no interference with the activities of daily living.

In deposition, the Agreed Medical Evaluator acknowledged the inconsistency in his rating when compared with the medical records and applicant's deposition. Per the *Guides* applicant would have no more than 7% whole person impairment. Parties proceeded to trial on the nature and extent of injury and permanent disability.

The trial judge awarded 15% permanent disability and found injury to the left knee by way of compensable consequence. Defendant sought reconsideration, which was granted.

The Workers' Compensation Appeals Board found the 15% permanent disability rating was unsupported by the facts and there was lack of any evidence to support a left knee injury. The AME's rating as to the 7% whole person impairment was adequately explained, supported by the evidence and, therefore, should have been followed.

Accordingly, the Board amended the Findings of Fact to limit injury to the right knee only; defer the award of permanent disability, and returned the matter to the trial level for a new permanent disability rating to the right knee which had to take into consideration apportionment for the prior awards.

Riley vs. City of Pasadena

WCAB AUTHORIZES PHYSICIAN'S "RATING BY ANALOGY"

Laury vs. State Compensation Insurance Fund 39 CWCR 67 (2011)

Applicant sustained accepted injury to his spine while lifting in the course of his employment as a cement mason. The injury also resulted in psychiatric disability and sexual dysfunction.

The parties utilized an AME who found that applicant was permanent and stationary as of June 10, 2009. In his report, the doctor stated that "WPI was determined both per the DRE and ROM method and the ROM yielded the higher result. Also, note that I have analogized [applicant's] sleep disturbance and sexual dysfunction which are a result of medications and pain..." The doctor stated that rating by analogy "may be more in keeping with the actual impact on [applicant's] ability to work. To do so, I refer the parties to figure 15-19 on page 427 [of the AMA Guides]" (which converts Whole Person Impairment into regional spine impairment). The doctor notes that "this rating takes into account the method allowed by the recent Almaraz/Guzman decision."

Following a trial, the Workers' Compensation Judge issued a Findings and Award which, among other things, found that the AME's opinion had not rebutted the Whole Person Impairment aspect of the 2005 permanent disability rating schedule. Applicant sought reconsideration which was granted.

The Board found that the Workers' Compensation Judge should have relied on the AME's opinion and found that the WPI aspect of the 2005 permanent disability rating schedule had been rebutted. Referring to the language in Almaraz/Guzman, that when determining an injured employee's Whole Person Impairment, it is not permissible to go outside the four corners of the AMA Guides, the Board noted that a physician may use any chapter, table or method in the Guides that most accurately reflects the injured employee's impairment and that figure 15-19 is within the four corners of the Guides.

The AME's report noted that applicant had lost 60% of the use of his lumbar spine and that neither the DRE nor ROM method of rating fully reflected the applicant's level of work impairment. He then provided an alternate method using figure 15-19. The Panel concluded that use of that alternate method was appropriate taking into consideration the doctor's expertise as a physician and AME.

Laury vs. State Compensation Insurance Fund

SEPARATE RATING OF “GRIP LOSS” INAPPROPRIATE WHERE THERE IS NO EVIDENCE THAT APPLICANT’S IMPAIRMENT IS NOT ADEQUATELY CONSIDERED IN RANGE OF MOTION TESTING

Lopez vs. WCAB 76 CCC 180 (Writ Denied 2011)

Applicant sustained injury to his left ring and little fingers when he hit a saw blade. Both the primary treating physician and Panel QME provided reports in which applicant’s Whole Person Impairment was based on loss of motion.

When the matter went to trial, the Workers' Compensation Judge issued rating instructions based on grip loss. Based on this instruction, the DEU Rater issued a Recommended Rating of 19% permanent disability. On cross examination, the Rater testified that had she rated the decreased range of motion described in the reports, the permanent disability would have been 7%. The Workers' Compensation Judge issued an award of 19% permanent disability and the defendant sought reconsideration.

The Workers' Compensation Appeals Board noted that the AMA Guides do not generally provide for impairment determinations based on grip strength tests because such measurements are subjective and may be influenced by the patient’s efforts. The Guides for the most part assess objective anatomic impairment. In rare cases, grip strength may be used if the examiner believes that the loss of grip strength represents an impairing factor that has not been adequately considered by other methods, such as a severe muscle tear. Impairment due to loss of strength could be combined with other impairments only if based on unrelated etiologic or pathomechanical causes. Decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities or absence of parts (i.e. amputations) that prevent effective application of maximal force in the region being evaluated.

While the Panel QME did provide grip loss measurements in his permanent and stationary report, there was nothing in the report to suggest that the range of motion method he used to rate the applicant did not adequately consider grip loss. Absent a finding by the QME that the applicant’s grip loss was not adequately considered in the range of motion testing and that there was impairment from other unrelated etiologic or pathomechanical causes, the AMA Guides provide that grip loss is not an appropriate method for evaluating the applicant’s impairment.

The WCAB granted defendant’s Petition and issued a new award of 7% based on the range of motion testing described in the Panel QME’s report.

Lopez vs. WCAB

Applicant filed a Petition for a Writ of Review, which was denied.

NOTE: Other decisions under Almaraz/Guzman have allowed a rating for grip loss. However, those cases involve a report in which the doctor explained why, in his opinion, grip loss provided a more accurate rating.

**INSIGNIFICANT UNAUTHORIZED EX PARTE COMMUNICATION
WITH QME SHOULD NOT INVOKE REMEDY UNDER
LABOR CODE §4063.2 (NEW PANEL QME)**

Alvarez vs. WCAB, 187 CA4th 575, 75 CCC 817 (2010)

Applicants were the widower and 2 minor children of a waitress who died from a cerebral hemorrhage and hypertension allegedly caused by her employment. State Compensation Insurance Fund (SCIF) denied the claim.

To resolve the AOE/COE issue, a Panel QME was appointed. He issued a report dated September 20, 2008.

In order to obtain clarification on certain issues in the report, the doctor was deposed on December 4, 2008. He testified that certain medical records showed that the decedent suffered from a number of stressors in her personal life, including allegations that her husband had sexually abused one of the children, resulting in the decedent obtaining a restraining order. However, the doctor could not specify which records contained this information. The parties agreed that the doctor would again review the records and identify for them the records relied upon.

The day following the deposition, the doctor telephoned defense counsel stating that the medical file could not be located and requested another copy.

Defense counsel then wrote to applicant's attorney indicating that he had received the call from the doctor and would be forwarding another copy of the medical file.

Applicant's attorney wrote back that defense counsel had "clearly violated the Labor Code by having an ex parte communication with the PQME". He requested that the PQME report be stricken, that a new QME Panel issue and that sanctions and penalties be imposed.

At trial on the issues, defense counsel advised the Workers' Compensation Judge that the doctor had initiated the call, the nature of the call, that no substantive issues were discussed and that he immediately advised opposing counsel of the call.

The Workers' Compensation Judge found no improper communication.

Applicant sought Reconsideration, which was denied. The Workers' Compensation Appeals Board found that while the call from the doctor was an ex

parte communication, it involved only administrative matters, rather than substantive issues.

Applicant petitioned for a Writ of Review, which was granted in May 2010. The Court of Appeal stated that Labor Code §4062.3(e) prohibits ex parte communications of any kind with the QME. It does not matter who initiated the communication. The Statute does not differentiate between “administrative” and “substantive” communications. The Court found that since there was an improper ex parte communication, the remedy was exclusion of the QME’s report and issuance of a new Panel.

Subsequently, in August 2010 defendant’s Petition for Rehearing was granted by the Court of Appeal. At that time, the prior Decision was annulled and the matter remanded.

The Court stated that that although Labor Code §4062.3 expressly prohibits ex parte communications with the Panel QME, (except for an employee or deceased employee’s dependents in connection with the examination), because it is recognized that there is a certain degree of informality in workers’ compensation proceedings, not every conceivable ex parte communication would permit a party to obtain a new evaluation from a Panel QME. The Court stated that some ex parte communications may be so “insignificant and inconsequential,” there would be no resulting repercussion. The matter was remanded to the WCAB to re-evaluate its conclusion based upon the principle involved and *not* based upon the distinctions between the administrative versus substantive nature of the communication.

Therefore, if an ex parte communication is deemed inconsequential, there would be no consequences to contend with. However, if an ex parte communication violates the provisions of §4062.3, a new Panel QME would be awarded.

**OBJECTION TO LATE QME REPORT WAIVED IF OBJECTION IS NOT
MADE UNTIL AFTER THE REPORT IS ISSUED**

Ruzan Charkchyan vs. WCAB (Glendale Unified School District)
75 CCC 1183 (Writ Denied; September 23, 2010)

Applicant alleged cumulative trauma while employed by the Glendale Unified School District. He was evaluated by a Panel QME.

The doctor served his report on April 24, 2009, one day after the 30-day time frame called for in Labor Code §139.2(j)(1)(A). On April 28, 2009 (after the doctor had served the report, but before it was received by the applicant), the applicant objected to the report as untimely and requested a new QME Panel pursuant to Labor Code §4062.5.

The matter was tried on the sole issue of applicant's objection to the Panel QME report.

The Workers' Compensation Judge found that the objection to the report was untimely and that applicant was not entitled to a new Panel. Applicant petitioned for Reconsideration, contending that he was entitled to a new Panel as a matter of law because the QME report was not timely.

The Workers' Compensation Appeals Board adopted the Workers' Compensation Judge's reasoning in his report and recommendation denying reconsideration. The Workers' Compensation Judge noted that 8 CCR 31.5(a)(12) provides that a replacement QME Panel will issue when the evaluator fails to meet the required deadlines and the party requesting the replacement objects on the grounds of lateness prior to the date the evaluator served the report.

In this case, the report was served on April 24, 2009, but the applicant did not object until April 28, 2009. Consequently, the objection was waived.

Applicant petitioned for a Writ of Review, which was denied on September 23, 2010.

**REMEDY FOR PANEL QME'S FAILURE TO ISSUE TIMELY
SUPPLEMENTAL REPORT IS ISSUANCE OF NEW PANEL**

Lloyd vs. County of Alameda [ADJ 7006889 (February 28, 2011)]

Applicant alleged that she sustained an industrial injury to the psyche on July 11, 2009. The claim was denied.

A Panel QME was appointed and issued a report dated September 9, 2010 in which he found no industrial injury due to the defendant's good-faith personnel actions. However, such a finding is a legal issue to be decided by the Workers' Compensation Judge, not a medical issue to be addressed by the QME.

Since the doctor's conclusion on causation did not have an adequate medical basis, it would not constitute substantial medical evidence. Therefore, defendant's counsel requested a supplemental report.

The QME did not issue the supplemental report within 60 days and applicant's attorney requested a new QME panel. The defense counsel objected to that request, arguing that 8 CCR 38(h) does not contain a provision allowing for the issuance of a new panel if the report is not issued within 60 days. The issue was presented to the Workers' Compensation Judge who ordered a new panel. Defendant petitioned for removal.

The Board Panel adopted the Workers' Compensation Judge's report and recommendation in which she noted that 8 CCR 38(a) permits the issuance of a new Panel if a "follow-up comprehensive medical/legal evaluation report" is not issued within 30 days. She analogized the "supplemental reports" discussed in 8 CCR 38(h) to the "follow-up" reports described in 8 CCR 38(a) and determined that the remedy for a late report in either situation should be the same – a new panel.

APPLICANT ALLOWED TO REOPEN CLAIM TO ALLEGE NEW BODY PARTS NOT COVERED BY ORIGINAL STIPULATIONS

California Highway Patrol vs. WCAB (Griffin)
75 CCC 1241 (Unpublished; November 19, 2010)

Applicant, a California Highway Patrol Officer, alleged cumulative trauma to his neck, back, right hand, gastrointestinal, headaches, bilateral knees and feet and right hip through July 22, 1999. On July 23, 2003, the parties agreed to a Stipulated Award of 25% permanent disability.

On May 11, 2004, the applicant filed a Petition to Reopen and included as additional body parts his “left thumb and left hand (trigger finger)”. He later amended the Petition to Reopen to include injury to his heart.

The Workers' Compensation Judge denied the petition, finding that the applicant had not carried his burden of showing that the new body parts were either causally connected to the original ones, or were a compensable consequence of them. Applicant sought reconsideration.

The WCAB reversed the Workers' Compensation Judge and allowed the new body parts. The CHP then sought reconsideration, which was denied.

The Board specifically ruled that it was not relying on the theory that the new body parts were either causally connected or a compensable consequence of the originally-settled body parts but, rather, that the officer could reopen because he carried his burden of simply showing that the new body parts were (a) employment-related, (b) occurred during the same cumulative period as the original body parts and (c) manifested after the original stipulations.

The defendant then Petitioned for a Writ of Review which was denied. The Appellate Court said it was settled law that one can reopen by just showing that evidence was not reasonably available during the original proceedings and stipulations. “In order to constitute ‘good cause’ for reopening, new evidence (a) must present some good ground, not previously known to the Appeals Board, which renders the original award inequitable, (b) must be more than merely cumulative or a restatement of the original evidence..., and (c) must be accompanied by a showing that such evidence could not with reasonable diligence have been discovered and produced at the original hearing.”

Here, there was ample medical proof that the heart and left hand injuries had not manifested by the time the original stipulations were signed.

California Highway Patrol vs. WCAB (Griffin)

The Court said that since the officer's evidence adequately linked the new body parts to his employment and also showed that they occurred during the same employment period as the original stipulations, he had every right to reopen for "newly-discovered evidence" under Labor Code §5803: "Here, the WCAB found an industrial injury to Griffin's left hand and heart developed during employment but each manifested itself after the issuance of the stipulated award. Further, both [doctors] provided evidence that these injuries have increased Griffin's level of disability. Thus, there was evidence supporting the WCAB's determination that there was good cause to reopen under the provision of Section 5803, because there was newly discovered evidence which could not have been produced earlier and which demonstrated Griffin had a more extensive disability than recognized at the time of the stipulated award."

Significantly, the Court did not require any showing that the new injuries were somehow related to the originally stipulated injuries.

KNOWLEDGE OF INJURY PRIOR TO STIPULATED AWARD BARS PETITION TO REOPEN

State Compensation Insurance Fund vs. WCAB (Hancock)
75 CCC 1336 (Unpublished; November 22, 2010)

Applicant alleged cumulative trauma to his low back, bilateral hands and bilateral knees through July 31, 2001. In 2005, the parties settled the claim by stipulations at 49% permanent disability.

Later in 2005, applicant petitioned to reopen his claim and alleged injury to new body parts including his bilateral shoulders. To address the issues raised in the Petition to Reopen, the applicant was re-evaluated by the Agreed Medical Examiner upon whose reports the case was originally settled. The doctor noted in his report that the applicant, during his initial evaluation, had marked the shoulder area on a pain diagram. However, the doctor never addressed the shoulders in his initial report. The doctor then offered the opinion that the applicant had injured the shoulders via the same mechanism of cumulative trauma that resulted in injuries to the other body parts.

The Workers' Compensation Judge initially denied the Petition to Reopen on the ground that there was no causal connection between the new body parts (shoulders) and the original body parts. However, after applicant petitioned for reconsideration, the Workers' Compensation Judge vacated his decision and found that applicant had sustained injury to his shoulders on an industrial basis.

The Workers' Compensation Appeals Board denied defendant's Petition for Reconsideration and defendant sought a Writ of Review, which was granted.

The Court of Appeal, using the same analysis as in the Griffin case found that reopening under Labor Code §5410 requires a causal connection with the original injured body parts. The Court then addressed Labor Code §5803, noting that in order to constitute "good cause" for reopening under this Labor Code Section, any new evidence must be accompanied by a showing that such evidence could not with reasonable diligence have been discovered and produced at the original hearing.

When applicant was originally evaluated by the AME, he reported pain in his right shoulder and recalled a specific left shoulder injury 15 years in the past that had been a continuing problem for him. Yet the AME did not address the shoulders in his original report. The Court noted that when the AME produced a report that omitted mention of an injury to the shoulders, applicant who was represented by

State Compensation Insurance Fund vs. WCAB (Hancock)

counsel, should have pointed the omission out to the doctor. In the absence of evidence of due diligence, the Court found no newly discovered evidence and no good cause to reopen under Labor Code §5803.

**COMPENSABLE CONSEQUENCE REQUIRES A CAUSAL
CONNECTION BETWEEN THE INDUSTRIAL INJURY AND
SUBSEQUENT INJURY**

Craig vs. WCAB 75 CCC 1192 (Writ Denied; August 10, 2010)

Applicant sustained an admitted injury to his right shoulder on October 7, 2007. On January 3, 2008, while on temporary disability and with his right arm in sling, he claimed he suffered a compensable consequence injury to his left shoulder because he was required to put undue stress on the shoulder while placing bricks on the roof of his cabin in order to protect it from an upcoming storm.

Applicant's treating doctor and the Panel QME said that the left shoulder injury was caused by the inability to use the right arm.

A Workers' Compensation Judge found the left shoulder injury was not a compensable consequence because it was too remote from the original injury. Applicant filed a Petition for Reconsideration, which was denied. He then Petitioned for a Writ of Review which, was also denied.

The Court of Appeal noted that, although the original injury only needs to be a contributing factor of a subsequent injury to trigger compensability and mere carelessness or negligence of the applicant does not break the causative chain, the chain is broken as to the subsequent injury if the later injury is caused by risky or rash acts by the employee with full knowledge of the risk involved. Here, the Workers' Compensation Judge found the applicant tried to fix a roof knowing his limitations. Applicant's conscious disregard for his physical condition was enough to break the causative chain.

**DEFENDANT IS RESPONSIBLE FOR HOME HEALTH SERVICES
ONLY TO THE EXTENT THAT THEY ARE NECESSARY AND
REASONABLE**

State Farm vs. WCAB 76 CCC 69 (January 26, 2011)

Applicant sustained injury to her psyche, lumbar spine and right upper extremity and developed fibromyalgia, resulting in 100% permanent disability. Applicant's husband provided certain home health services for his wife, for which he filed a lien.

The Workers' Compensation Judge originally disallowed the lien due to the lack of supporting evidence and the husband sought reconsideration. The WCAB granted the petition and returned the matter to the Workers' Compensation Judge with instructions to further develop the record.

The parties were unable to agree on a medical expert to address the reasonableness of the home health services. Therefore, the Workers' Compensation Judge ordered the parties to utilize a Dr. Barras for an expert opinion on the subject.

Without notice to the defendant, counsel for the applicant and her husband arranged for an evaluation with Dr. Barras and provided her with some, but not all, of the medical records. They also failed to advise the doctor of the specific questions that the Workers' Compensation Judge had posed. The doctor then issued a report setting forth all of the applicant's medical needs and their expected costs. She also opined that the husband's services were valued at \$35.00 per hour.

Counsel for defendant deposed the doctor and then moved to exclude the report due to the ex parte communication. The motion was denied, the Workers' Compensation Judge finding that any defect in the report could be cured by the deposition and a supplemental report. Thereafter, the matter was submitted for a decision.

The Workers' Compensation Judge found that applicant required 24 hour attendant care services, 7 days per week at the rate of \$720.00 per day for more than 7 years – a total of 1.5 million dollars.

The defendant filed a Petition for Reconsideration, which the WCAB denied. The Board found that the applicant's ex parte communication with the doctor did not require exclusion of her reports or opinion.

The defendant sought a Writ of Review in the Court of Appeal, which was granted.

The Court found that the ex parte communication involved the merits of the case and not merely procedural matters. Therefore, they violated 8 CCR 10718 [now section 10213] and required that the medical report be stricken and a new medical examiner appointed.

With regard to the home health care lien, the Court found that the evidence for 24/7 care was lacking, since the timesheets submitted by the husband did not add up to 24 hours. Further, many of the services claimed did not constitute “medical treatment” for which the defendant was liable under Labor Code §4600.

The matter was remanded for appointment of a new medical examiner and a determination of the reasonableness and necessity of the home health care services claimed by the husband.

15% DECREASE IS ALLOWED ON ALL RETROACTIVE PERMANENT DISABILITY INDEMNITY PAYMENTS WHEN OFFER OF REGULAR WORK IS MADE, BEFORE PERMANENT AND STATIONARY REPORT ISSUES

Paine vs. City of Sebastopol 39 CWCR 16

A WCAB Panel determined that defendant was entitled to the 15% decrease to all retroactive permanent disability indemnity payments when the applicant had returned to work on April 14, 2008 and the employer made the offer of regular work on December 4, 2008, following receipt of a primary treating physician report dated November 26, 2008.

The Panel QME did not issue a permanent and stationary report until March 9, 2009 and permanent disability advances commenced on March 12, 2009. The Board noted that although permanent disability payments had to be paid retroactively from the date applicant returned to work, the defendant had the right to reduce the retroactive payments because the obligation to provide the payments did not arise until the QME described the factors of disability in his March report.

Kruse vs. City of San Rafael ADJ 6884562 (2010)

The applicant sustained an injury in April, 2008, but was only temporarily disabled for a brief period in December, 2008, after which he returned to his regular job. The treating physician found his condition to be permanent and stationary on June 11, 2009 and the employer made an offer of regular work on July 10, 2009. In October 2009, the parties stipulated to 6% permanent disability, but could not agree whether the total amount owed was subject to the 15% reduction.

The Workers' Compensation Judge found in January 2010 that the applicant was entitled to the full value of permanent disability, without reduction, because all of the permanent disability was accrued pursuant to Labor Code §4650(b).

On Reconsideration, the Board found that there was no indication in the medical records until the permanent and stationary report that the injury caused permanent disability. As a result, all permanent disability “remained to be paid” as of the date the employer made the offer of regular work. Although, pursuant to Section 4650(b), the permanent disability payments were payable retroactive to 14 days after the last payment of temporary disability benefits, the employer was still entitled to a reduction of 15% on all of the retroactive permanent disability payments.

Paine vs. City of Sebastopol; Kruse vs. City of San Rafael

**15% PERMANENT DISABILITY REDUCTION ALLOWED EVEN IF
THE OFFER OF REGULAR WORK WAS MADE BEFORE A FINDING
OF PERMANENT AND STATIONARY STATUS**

Hilpert vs. City of Santa Rosa ADJ 7306545 (Panel Decision; January 10, 2011)

Applicant sustained an industrial injury to her left shoulder on July 29, 2009. Temporary disability was paid from August 26, 2009 through November 24, 2009. On December 5, 2009, the defendant made an offer of regular work, which the applicant accepted on January 8, 2010.

The Workers' Compensation Judge found that the applicant's condition did not reach permanent and stationary status until the treater's March 29, 2010 report and, therefore, the defendant's offer of regular work was not made within 60 days of the permanent and stationary status. He found that the permanent disability rate should be increased by 15% because the offer of work was not timely.

The WCAB Panel granted the defendant's Petition for Reconsideration and found that the applicant returned to full duty the day after temporary disability ended. They also found that the defendant issued the offer of regular work just over two weeks later. In doing so, the defendant returned a permanently disabled worker to work at the earliest available opportunity. This is consistent with the underlying purpose behind the implementation of Labor Code §4658(d)(3)(A), and they were entitled to the 15% decrease on the retroactive PD beginning 11/09, when TD ended.

Quintero vs. City of Sebastopol ADJ 7219970 (2011)

Applicant was injured on November 20, 2008 and was assigned to modified duties. He continued in the modified duties until May 11, 2009 when he became temporarily disabled for three days. Thereafter, he returned to modified duty until released to full duty by his treating physician on October 16, 2009. Defendant made an offer of regular work on October 22, 2009. The applicant was declared permanent and stationary as of February 23, 2010. However, the employer did not make another offer of regular work.

In this Panel Decision, the WCAB concluded that an offer of work after an applicant had been returned to regular work, but before he was permanent and stationary, entitled the employer to the 15% decrease in permanent disability indemnity pursuant to Labor Code §4658(d)(3)(A).

Hilpert vs. City of Santa Rosa; Quintero vs. City of Sebastopol

**EMPLOYER MUST OFFER REGULAR WORK (L.C.§ 4658(d)) WHERE
EMPLOYEE IS RETIRED, OR PAY 15% INCREASE IN PD**

Kings County vs. WCAB (Revious) 76 CCC 378 (March 10, 2011; writ denied)

Applicant, a Deputy Sheriff, alleged a cumulative trauma injury to his right hip through February 1, 2006. He voluntarily retired from his position on August 14, 2006.

The parties selected an AME who issued a report in which he opined that applicant had reached maximum medical improvement as of January 22, 2008. The report stated that the applicant was limited to semi-sedentary work and that he should be precluded from prolonged weight-bearing, running and jumping. Because the applicant had been retired for more than a year, the County did not issue an offer of regular work.

Following a trial, the Workers' Compensation Judge issued an award of 15% permanent disability, after apportionment. He also found that the applicant was entitled to a 15% increase in permanent disability indemnity pursuant to Labor Code §4658(d)(2).

The County petitioned for reconsideration, arguing that the applicant was not entitled to the Labor Code §4658(d)(2) increase because he voluntarily retired. Therefore, the County had no obligation to offer regular work.

The WCAB disagreed. They determined that, under a strict reading of the Statute, in order for the defendant to gain the benefit of Labor Code §4658(d), the defendant must offer the applicant regular, modified or alternative work within 60 days after his condition becomes permanent and stationary. The Board found that it made no difference that the applicant had retired.

The County petitioned for a Writ of Review, which was denied.

**SYMPTOMS ASSOCIATED WITH INJURY TO THE PSYCHE MAY BE
BIFURCATED AND MAY NOT BE SUBJECT TO THE “GOOD-FAITH
PERSONNEL ACTION” DEFENSE**

County of San Bernardino vs. McCoy 76 CCC 504 (March 28, 2011; writ denied)

Applicant alleged that he suffered a psychiatric injury during the period July 2005 through January 19, 2006 while employed by the County of San Bernardino. The County denied the claim, asserting a good-faith personnel defense under Labor Code §3208.3(h).

The matter went to trial at which time the applicant added a claim of migraine headaches. The Workers' Compensation Judge issued a Findings and Award in which he found that both the psychiatric injury and migraine headaches were related to the applicant's work. However, he also found that the claims were barred by the good-faith personnel action defense.

The applicant sought reconsideration, which was granted. The WCAB found that the Workers' Compensation Judge erroneously applied the good-faith personnel action defense to the headache claim. They found no error in applying the defense to the claim of psychiatric injury.

The County sought reconsideration, contending that in order for the migraine headaches to be compensable, the applicant's job must be “inherently stressful” and that the sole factor contributing to the headaches was the good-faith personnel action.

The Workers' Compensation Appeals Board denied the petition. The Board noted that migraine headaches are not within the definition of a psychiatric injury as described in Labor Code §3208.3(a). Consequently, the good-faith personnel defense does not apply.

The County sought a Writ of Review, which was denied on March 28, 2011.

Following the denial of its writ petition, the County petitioned for review by the Supreme Court, arguing that it was error to treat the psychiatric and migraine headaches as two distinct injuries. Rather, the County contends that the migraines should be considered a “symptom” of the psychiatric injury.

The Supreme Court has granted the County's petition and has transferred the matter back to the Fourth District Court of Appeal for further review. The matter is now pending.

35% THRESHOLD REQUIRED TO BAR COMPENSATION UNDER GOOD-FAITH PERSONNEL ACTION DEFENSE

San Francisco Unified School District vs. WCAB 38 CWCR 289 (2010)

Applicant, an elementary school teacher, claimed a CT injury to the psyche caused by the stress of her teaching duties. Defendant claimed it had unsatisfactory performance reviews for the applicant, along with written disciplinary warnings, and that the claim was barred under Labor Code §3208.3(h) – the good-faith personnel action defense.

The Agreed Medical Examiner determined that 15% of the applicant's impairment was apportioned to personnel issues and that 85% was associated with her employment. He then concluded that 60% of the 85% was related to difficulties of daily teaching activities, with 40% associated with non-discriminatory, good-faith personnel actions. He concluded that 51% of the applicant's overall impairment was apportioned to classroom teaching factors (60% of 85%) and that 34% would be associated with the personnel action (40% of 85%).

The Workers' Compensation Judge ruled that the applicant sustained an industrial psychiatric injury; that 15% of the injury was caused by non-industrial factors; that 51% was related to classroom teaching activities and 34% to "personnel actions" and, therefore, that defendant did not meet its burden of proof regarding the good-faith personnel action defense. The Workers' Compensation Judge noted that Labor Code §3208.3 requires the good-faith personnel action to contribute at least 35 to 40% of the injury and, therefore, defendant had fallen short by 1%. The defendant filed a Petition for Reconsideration, which was denied. The defendant then petitioned for a Writ of Review.

The Court of Appeal denied the Petition. The Court analyzed the good-faith personnel action defense as follows:

First, the Workers' Compensation Judge must determine whether the alleged psychiatric injury involves actual events of employment and, if so, whether competent medical evidence establishes the requisite 51% of industrial causation.

Second, if these two criteria are met, then the Workers' Compensation Judge must decide whether any of the actual employment events constituted personnel actions.

San Francisco Unified School District vs. WCAB

Finally, if the Workers' Compensation Judge finds personnel actions, he must determine whether they were lawful, non-discriminatory and made in good faith. If so, then, per Labor Code §3208.3(h), the personnel actions must account for at least 35 to 40% of the psychiatric injury.

The Appeals Court rejected the defendant's contention that the "substantial cause calculation" under Labor Code §3208.3(h) should not include non-industrial factors. The Court pointed out that §3208.3 specifically refers to "all sources combined" in calculating the percentage of psychiatric injury caused by good-faith personnel actions. "All sources combined" can only be interpreted to mean industrial and non-industrial sources. Therefore, the entire set of causative factors must be taken into consideration when determining whether or not a psychiatric injury was substantially caused by good-faith personnel actions.

**ASSAULT NOT A SUDDEN AND EXTRAORDINARY EVENT
OVERCOMING SIX MONTH EMPLOYMENT REQUIREMENT FOR
PSYCH CLAIM**

Jackson vs. City of Los Angeles Dept. of Transportation
38 CWCR 306 (October 4, 2010)

Applicant, a traffic officer, was injured when she was struck by a car whose driver she was trying cite. Defendant admitted liability as to the orthopedic claims, but denied liability for a claimed psychiatric component because the applicant had not been employed for at least six months prior to the date of injury.

At trial, the applicant testified that she was writing the citation when the driver of the vehicle came out of the building, shouted at her, got into his vehicle and backed into her. Applicant's supervisor testified that the applicant should have stepped aside to avoid being struck. He also recalled at least three similar incidents and, in his opinion, being run into was a normal hazard of attempting to issue a ticket. The supervisor felt moving out of the way of a moving vehicle would be an ordinary event. The Workers' Compensation Judge ruled that the psych injury was compensable and that this incident constituted an uncommon, unusual and unexpected event.

Defendant petitioned for reconsideration, which was granted. The Board found that the applicant had not met her burden of proof. A sudden event is one that happens without previous notice or with very brief notice. An event is extraordinary if it is unusual, uncommon or irregular. Given the evidence presented, especially the testimony of the supervisor, this event was neither sudden nor extraordinary.

Jackson vs. City of Los Angeles Dept. of Transportation

WCAB DEFINES ROLES OF PHYSICIAN, WCJ AND DEU RATER

Blackledge vs. Bank of America 75 CCC 613 (en banc; June 3, 2010)

In this case, the Board unanimously clarified the respective roles of the evaluating physician, the Workers' Compensation Administrative Law Judge and the Disability Evaluation Specialist (DEU Rater) in determining Whole Person Impairment under the AMA Guides, with 6 specific holdings:

1. The role of the physician is to assess the injured employee's Whole Person Impairment percentage in a report which sets forth facts and reasoning to support its conclusions and that comports with the AMA Guides and case law. In this context, the Board goes on to clarify that "It is essential for a medical report to state the physician's actual WPI rating for each medical condition", noting that the AMA Guides cannot be "mechanically" applied. Without specifically commenting on the Almaraz/Guzman decision, the Board does seem to acknowledge and incorporate those holdings.
2. The role of the Workers' Compensation Judge is to frame instructions, based on substantial evidence and fully describe the Whole Person Impairment to be rated. The Board notes that a Workers' Compensation Judge may ask a Rater to offer an opinion on what Whole Person Impairment should or should not be rated.
3. The role of the DEU Rater is to issue a recommendation which is based solely on the Workers' Compensation Judge's formal rating instructions. Unless specifically instructed to do so, a Rater has no authority to issue a rating based on the Rater's own assessment of whether the Whole Person Impairment referred to in the instructions is based on substantial evidence or is consistent with the AMA Guides.
4. A Workers' Compensation Judge is not bound by a Rater's recommended permanent disability rating and a Workers' Compensation Judge may elect to independently rate an employee's permanent disability. However, a Workers' Compensation Judge's rating still must be based on substantial evidence. The Board noted that a Workers' Compensation Judge is considered an expert in rating and, thus, is an appropriate party to provide a permanent disability rating.

Blackledge vs. Bank of America

5. Potential AMA Guide rating problems may be minimized by the early and proper use of non-formal ratings. Noting the three types of non-formal ratings (Summary Rating Determinations, Consultative Rating Determinations and Informal Rating Determinations) the Board noted the use of these vehicles could “facilitate the determination of permanent disability”, and instructs the Rater to utilize the Whole Person Impairment percentages specified in the physician’s report and to use his or her expertise to annotate any errors that would result in a different Whole Person Impairment if the AMA Guides was correctly applied.
6. In the context of a formal rating, there must be no *ex parte* communication between the Workers' Compensation Judge and the assigned Rater. The Board goes on to clarify that informal consultation with a Rater is not always prohibited and specifically states that a Judge may informally consult with a Rater, for example, on a case for which she is reviewing a proposed settlement for adequacy or at an MSC or Rating MSC. The ultimate purpose of obtaining an informal rating is to help ensure the reports upon which the Workers' Compensation Judge is relying to frame rating instructions, are substantial evidence and to obviate the delays and additional expense caused by challenges to the rating instructions or ratings.

COURT OF APPEAL ORDERS APPORTIONMENT WHEN AME OPINION MEETS STATE STANDARDS

Solano County Probation Dept. vs. WCAB (Aguilar) (ADJ 4289752)

Applicant suffered injuries to her left shoulder, left elbow, low back, and left hip in the course of her employment with Solano County Probation Dept. The Agreed Medical Examiner noted that the applicant had pre-existing arthritis in her left hip. However, he concluded that the arthritis was not symptomatic or disabling. Therefore, in his opinion, all of the applicant's hip disability should be apportioned to cumulative trauma from her work. The opinion on apportionment in the October 2002 report was consistent with then-existing law.

When the AME examined the applicant again in January 2005 (after she had had hip replacement surgery), his report noted "new rules" which might require apportionment. If so, he believed there was "disease and pathology" to apportion to the left hip disability. In his opinion, "approximately two-thirds of her disability is a direct result of cumulative trauma and one-third is the result of disease and pathology". 100% of the applicant's left shoulder disability was the result of cumulative trauma from her work.

In May 2006, the AME prepared a report solely on the subject of apportionment. First, with respect to applicant's spine disability, the doctor explained that "growing evidence in medical literature" showed obesity played a role in "spinal disease and spinal problems". He noted that applicant met the body mass index criteria for obesity. He believed that approximately 10% of the spine disability was a "direct result of disease and pathology of obesity with the remainder going to cumulative trauma". Later, during his deposition, he changed his opinion on spine apportionment based on obesity after reading further medical articles on the topic. Following his deposition testimony, the doctor was of the opinion that all of the spine disability was industrial.

The apportionment issues were submitted to the Workers' Compensation Judge, who determined that none of the applicant's disability should be apportioned to non-industrial causes. First, the Workers' Compensation Judge believed the doctor had withdrawn obesity as a factor for apportionment: "Since [the doctor] withdraws any apportionment to obesity as to the back..., I assume he also meant to remove obesity as a factor of disability to other body parts". Second, the Workers' Compensation Judge found the AME's opinions confusing because he combined obesity with arthritis when speaking of non-industrial causation. Finally, the Workers' Compensation Judge concluded the AME had not sufficiently explained "how and why" the pre-existing factors caused disability.

Solano County Probation Dept. vs. WCAB (Aguilar)

The Workers' Compensation Judge did not describe why the doctor's explanation was insufficient.

The Board denied the employer's Petition for Reconsideration. The Court of Appeal in an unpublished opinion annulled the decision of the Board and remanded the case for further proceedings.

The Court found there was no substantial evidence to support the Workers' Compensation Judge's assumption that the AME withdrew his entire opinion on apportionment. The Court found that the doctor's reports and testimony adequately explained the basis for his opinions on apportionment under the standards set by the State's Courts. "The medical opinion must disclose familiarity with the concepts of apportionment, describe in detail the exact nature of the apportionable disability, and set forth the basis for the opinion, so that the Board can determine whether the physician is properly apportioning under correct legal principles." Since the doctor's opinion on apportionment was the only evidence in the record on the issue, there was no basis on which the Workers' Compensation Judge could reject it or assume it away.

MEDICAL EXPENSES MAY INCLUDE COST OF REASONABLE INTERPRETING SERVICES

Guiron vs. Santa Fe Extruders; State Compensation Insurance Fund
76 CCC 228 (March 17, 2011; en banc)

Applicant sustained an injury to his left elbow and psyche on April 14, 2006. Lien claimant, E&M Interpreting, provided Spanish translation services during applicant's medical appointments, including not only medical/legal evaluations, but also physical therapy, chiropractic and similar appointments.

The parties resolved the applicant's claim with a Compromise and Release, with SCIF agreeing to pay, adjust or litigate the E&M lien, which totaled \$13,988.00.

A lien trial was held on June 21, 2010. SCIF argued that interpreter fees were allowable only in connection with medical/legal evaluations and not for physical therapy or chiropractic visits. Agreeing with SCIF, the Workers' Compensation Judge awarded fees only for the initial and final evaluations performed by the applicant's primary treating physician. He disallowed the billings for the physical therapy and chiropractic treatment.

In an en banc decision, the WCAB granted E&M's Petition for Reconsideration.

The Board started its analysis with a review of the Labor Code and Administrative Director's rules addressing when a defendant is required to provide interpretation services. They noted that under Labor Code §4600, a defendant is required to provide medical treatment reasonably necessary to cure or relieve the injured worker from the effects of an industrial injury. In connection with the medical treatment, the defendant is required to provide "reasonably required" interpreter services for a worker who is unable to communicate in English. The Board found no merit to SCIF's distinction between providing interpreters for the primary treating physician visits, but not the physical therapy or chiropractic visits.

In order to recover for the interpreter services, the lien claimant has the burden of proving that the services were reasonably required, that the services were actually provided, that the interpreter was qualified and that the fees charged were reasonable. For example, the Commissioners noted that it might not be "reasonable" to provide an interpreter when the healthcare provider or the provider's staff spoke the employee's language. However, the employee is not limited to choosing only a provider who speaks his or her native language.

Guiron vs. Santa Fe Extruders; State Compensation Insurance Fund

In order to avoid these issues, the Commissioners recommended that the treating physician seek prior authorization for the interpreter services.

The matter was returned to the Workers' Compensation Judge for a determination of whether the interpreting services and charges met the “reasonableness” and “necessity” standard.

INTERPRETER CLAIMING LIEN NEEDS TO SHOW NECESSITY, QUALIFICATIONS AND REASONABLENESS

Garcia vs. Zurich American Insurance Company

39 CWCRCR 15 (Decision after Reconsideration; November 19, 2010)

Applicant, who spoke only Spanish, sustained an accepted injury to her right wrist on September 17, 2007. She selected as her treating physician, Paul Rhodes, D.C.

Claimant, “Word of Mouth” filed a lien in the amount of \$4,400.00 for interpreting services allegedly provided for the applicant during the chiropractic office visits. It provided itemized billing for 22 office visits at \$200.00 per visit. However, at the lien trial, the claimant conceded that none of its interpreters was State certified.

Defendant introduced as evidence an advertisement for Dr. Rhodes’ office indicating that the office could accommodate Spanish-speaking patients. The adjuster for the defendant testified that he had called the chiropractor’s office and was told that the chiropractor, as well as his staff, spoke Spanish.

The Workers' Compensation Judge allowed the lien and ordered the defendant to pay.

Defendant petitioned for reconsideration arguing that the lien claimant failed to carry its burden showing that the charges were reasonable or necessary. The Workers' Compensation Appeals Board granted the Petition, noting that based on the evidence presented, the claimant did not prove its services were necessary or that the charges were reasonable.

**COMPLETE FILE NECESSARY IN ORDER FOR
WCAB TO RULE ON PETITIONS**

Hernandez vs. AMF Staff Leasing 76 CCC 343 (April 11, 2011; en banc)

Applicant sustained an industrial back injury on October 21, 2001. During the course of the claim, applicant's attorney noticed the deposition of the claim adjuster and included a demand for production of certain documents, including all Utilization Review referrals and responses.

Defendant moved to quash the Notice of Taking Deposition and the production of documents.

After the Motion was filed, a Mandatory Settlement Conference was scheduled at which the parties filled out a Pre-Trial Conference Statement and each side listed exhibits. A number of the exhibits were simply identified by reference to documents supposedly already in the Board's file.

The Workers' Compensation Judge issued an Order compelling the defendant to produce the claim adjuster for deposition and to produce the documents requested. Defendant filed a Petition for Removal. [Subsequent to filing the Petition the parties resolved the underlying case with a Compromise and Release. However, the Board did not receive notice and, wanting to send a message to the workers' compensation community, issued an en banc decision addressing the status of the file submitted for review.]

During its review of the file, in order to address the Petition for Removal, the Commissioners were unable to locate several of the documents referred to by the parties.

The Commissioners cite several Board rules pertaining to the contents of the Board files and the documents that are to be maintained in the files. While acknowledging the District Offices' problems with scanning EAMS documents and manpower issues caused by the State's budget crisis, the Commissioners stated that it is still the litigants' responsibility to "ensure that a complete and properly organized record is available to the Appeals Board."

If the documents are not scanned into EAMS, the parties are to make sure that paper documents are placed in the file properly ordered, separated and bradded. The Commissioners stated that if they do not receive a complete file "we may be unable to rule on the Petition, or may act under the incorrect assumption that documents, which are waiting for scanning, do not exist."

Hernandez vs. AMF Staff Leasing

Therefore, in order to assure that Petitions for Reconsideration/Removal or other submissions to the Board receive full consideration, one must assure that they receive a complete file addressing all of the relevant issues.

**IMPROPER ORDER APPROVING COMPROMISE AND RELEASE IS
FINAL UNLESS APPEALED**

Barajas vs. F & H Cold Storage (ADJ 6559495) (September 7, 2010)

The parties entered into a Compromise and Release, which included language that “defendant will pay, adjust or litigate all liens filed on or before the date of the Order Approving Compromise and Release, which are subject to the WCAB’s jurisdiction.” The Workers' Compensation Judge, however, issued an Order Approving Compromise and Release which contained the following language: “Defendants are ordered to pay, adjust or litigate and hold applicant harmless from all industrial liens of record not otherwise specified. The Board retains jurisdiction on these liens.”

The defendant did not challenge the order.

A lien claimant then filed a lien, which the defendant refused to pay. At the lien trial, the Workers' Compensation Judge ordered defendant to pay the lien and the defendant petitioned for reconsideration, contending that the Workers' Compensation Judge’s original order was improper.

The Workers' Compensation Appeals Board denied the defendant’s petition. The Board Panel acknowledged that the Workers' Compensation Judge did overreach in re-writing the provisions of the Compromise and Release. However, once he included the “hold harmless” language in the Order Approving Compromise and Release, the defendant should have sought reconsideration. Once the time limit to seek reconsideration ran, it became a final order, regardless of the Workers' Compensation Judge’s inappropriate actions. Once final, the “hold harmless” provisions of the Order Approving Compromise and Release bound the defendant, not only to the workers’ compensation related bills, but also to non-work related costs.

INJURY OCCURRING WHILE MOVING CAR AFTER LEAVING THE OFFICE IS COMPENSABLE

Herndon vs. City of Pasadena 39 CWCR 11 (December 3, 2010)

Applicant's employer maintains two parking lots near the office where she worked. On December 31, 2009 when she arrived at work both lots were full, so she parked on the street. A short while later, when spaces became available, the applicant moved her car to one of the two employer provided parking lots. While crossing the street returning to her work place, the applicant was hit by a truck. Defendant denied her claim.

At trial, a guard testified that he told the applicant not to park on the street. Applicant's supervisor testified that the applicant never asked for permission to leave her work station to move her car and, although applicant was given breaks, they were to be taken at assigned times, which this was not. Applicant also had parked in a red zone and she should have known that parking there was illegal.

A Workers' Compensation Judge determined that the injury was non-industrial and the applicant petitioned for reconsideration.

The WCAB granted the petition and found the injury compensable.

The Board noted that in order to be compensable on an industrial basis, injuries must occur in the course of employment (which refers to the time, place and circumstances under which the injury occurs) and must arise out of employment (occur by reason of a condition or incident of the employment). Injuries in close proximity to the employment premises may arise out of employment (referred to at times as "the premises line"). Here, the applicant was crossing the street from an employer-provided parking lot to her place of work. The fact that she had left work to move an illegally parked vehicle was not a substantial factor. She was ultimately hit while returning to work from the employer-provided parking lot. The fact that she did not have permission to leave the office at the time of the injury also was not critical, because there was no evidence submitted by the defendant that leaving her workstation for a few minutes was strictly prohibited.

**REMOVAL OF PART OF BREAST IS AN “AMPUTATION” WITHIN
THE MEANING OF LABOR CODE §4656, ENTITLING APPLICANT TO
UP TO 240 WEEKS OF TEMPORARY DISABILITY**

Collinwood vs. Burrtec Waste Industries
(ADJ 2168776) (Panel Decision December 2009)

Applicant sustained injuries in a fall from a truck while employed as a welder. She had breast implants which were damaged in the fall and underwent surgery to repair the damaged implants. During the course of the surgery, the doctor found dense fibrotic tissues and determined that both implants should be removed. Consequently, the applicant was essentially left without breast tissue. As a result, the applicant contended that her breasts had been “amputated” and that she was entitled to additional temporary disability benefits pursuant to Labor Code §4656(3)(c).

Defendant argued that the removal of the breast implants was not an “amputation” because the surgery did not involve the complete removal of her breast, as in a mastectomy.

The Workers' Compensation Judge awarded the additional temporary disability payments and defendant filed a Petition for Reconsideration.

The Workers' Compensation Appeals Board adopted the Workers' Compensation Judge's report and recommendation denying reconsideration.

The Workers' Compensation Judge reasoned that, while the breast implants were “foreign material”, once they were implanted they became part of the applicant's body to which the muscle and tissue attached. Citing *Kruz vs. WCAB*, the Workers' Compensation Judge noted that an amputation is the “severance or removal of a limb, part of a limb, or other body appendage (emphasis supplied)”. Under *Kruz*, breasts would be considered “appendages” and the surgery here constituted a “partial amputation” of the breasts. Consequently, the applicant was entitled to the additional periods of temporary disability.

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