CASE LAW UPDATE
2020

The opinions expressed herein are not the opinions of the State of California, the Department of Industrial Relations, the Workers' Compensation Appeals Board, the Division of Workers' Compensation, or other judges. They are the opinions of the presenter only. Each case is different and must be evaluated on its own merits.

TABLE OF CONTENTS

COURT OF APPEAL CASES

1. Temporary disability

Skelton v. Workers' Compensation Appeals Board (Court of Appeal, published) 84 C.C.C. 795

Applicant claimed temporary disability indemnity for time lost from work to attend appointments for medical treatment following her return to work.

A hearing was held on Skelton's case before the workers' compensation judge (WCJ) on May 1, 2018.

Skelton's shoulder injury was found permanent and stationary on November 30, 2017. Her ankle injury was not yet permanent and stationary at the time of the hearing.

The WCJ issued a Joint Findings and Order, concluding that Skelton was not entitled to TDI to attend medical treatment based on the case of *Department of Rehabilitation v. Workers' Comp. Appeals Bd.* (2003) 30 Cal.4th 1281 (*Department of Rehabilitation*). Applicant filed a petition for reconsideration, arguing that she was entitled to TDI for all medical appointments after she exhausted her sick and vacation credits and until she was declared permanent and stationary.

In its Opinion and Order Granting Reconsideration and Decision After Reconsideration the majority stated that Skelton was entitled to TDI for wage loss to attend medical-legal evaluations, but that based on *Department of Rehabilitation* and *Ward v. Workers' Compensation Appeals Bd.* (2004) 69 C.C.C. 1179 (*Ward*) (writ denied), she was not entitled to TDI for wage loss to attend medical treatment following her return to work.

The dissent believed that Skelton was entitled to TDI for wage loss for attending medical-legal evaluations, as well as for attending necessary medical treatment. The matter went to the Court of Appeal.

In issuing the published opinion, the Court of Appeal stated that in *Department of Rehabilitation*, the California Supreme Court addressed whether an employee who had suffered an industrial injury was entitled to TDI to compensate the employee for taking time off from work for continuing medical treatment. (*Department of Rehabilitation*, supra, 30 Cal.4th at p. 1286.) The employee had returned to work after a determination that his injury was permanent and stationary.

The California Supreme Court concluded that the employee was not entitled to TDI under the circumstances. The court explained that the employee "had passed out of the healing period for which TDI serves as a wage replacement and had agreed to a stipulation compensating him for his diminished ability in the workplace due to a permanent and stationary injury. Because [the employee] had begun collecting PDI, he was no longer entitled to TDI."

The WCAB has interpreted *Department of Rehabilitation* to preclude TDI for work missed to attend medical appointments for an employee who has returned to work full time, regardless of whether the employee's injury is permanent and stationary. The WCAB has reasoned that an employee, by returning to work full time, no longer suffers from a wage loss coupled with an incapacity to work. Rather, the employee has restored his or her earning capacity, which eliminates the income replacement rationale underlying TDI.

In contrast, if an employee is requested to submit to a medical examination to resolve a compensation claim, and the request is by the employer, the employer's insurer, or another statutorily specified entity, then under section 4600 the employee is entitled to "one day of temporary disability indemnity for each day of wages lost in submitting to the examination."

The Court of Appeal determined that Skelton was not entitled to TDI for wage loss arising from her time off from work to attend appointments for medical treatment. The employer's obligation to pay temporary disability benefits is tied to applicant's actual incapacity to perform the tasks usually encountered in employment and the wage loss resulting therefrom.

In this case, Skelton admits that she returned to work full time after her injuries. She subsequently took time off from work because she could not schedule medical treatment during non-work hours. She apparently began to suffer wage loss after using all her sick and vacation time. Neither Skelton's time off from work nor her wage loss was due to an incapacity to work. Rather, these circumstances were due to scheduling issues and her employer's leave policy. Because Skelton's injuries did not render her incapable of working during the time she took off from work and suffered wage loss, Skelton was not entitled to TDI for that time off or wage loss.

The decision was affirmed.

2. Lien fees

State Compensation Insurance Fund v. Workers' Compensation Appeals Board (Court of Appeal, not published) 84 C.C.C. 273

The Court of Appeal held that a medical provider's liens were valid despite failure to pay lien activation fees by the date of the scheduled lien conference, per statute. The fees should have been payable within what the court calculated was a 43-day grace period ordered by the federal court that had ruled that the statute was constitutional and lifted an injunction against collecting lien activation fees. When lifting the injunction, the federal district court ordered that the previously unpaid activation fees could be paid from November 9, 2015 through December 31, 2015.

In this case, the Court of Appeal affirmed the WCAB's finding that had rescinded a judge's decision that the lien was subject to being dismissed by operation of law because the lien activation fee had not been paid by the date of the November 17, 2015 lien conference, as apparently required by Labor Code §4903.06(a)(4).

The Court of Appeal first ruled that the WCAB decision was a final order and reviewable because the dismissal of liens determined a substantial right of the medical provider and a

substantial liability of the insurer and is a threshold issue in that it is a basis to the establishment of a provider's right to payment. Therefore, the judge's order dismissing the lien was a final order subject to judicial review.

The Court of Appeal then rejected State Fund's argument that there was nothing in the district court order allowing for additional time for the payment of lien activation fees after a lien conference or addressing a failure to pay such fees before the lien conference.

State Fund argued that since a lien conference in this case occurred before the last possible date to pay the lien activation fees, the fee should have been paid by the date of the conference, just as if the collection of such fees had never been enjoined. The court reasoned, however, that the federal district court order lifting the injunction, which required the state to reestablish, by November 9, 2015, a system for the payment of lien activation fees, provided that all affected lien holders shall be permitted to pay lien activation fees as required by Labor Code §4903.06 from November 9, 2015 through December 31, 2015. The ruling did not provide an exception for cases where a lien conference was held prior to December 31, 2015.

Therefore, based on that decision, the lien payment system had to be activated by November 9, 2015 and the affected lien holders had until December 31, 2015 to pay the activation fee. The decision intended that all lien holders would have a period of 43 days in which to pay the fee.

The court affirmed the order of the appeals board.

3. Jurisdiction

Allied Signal Aerospace, et al. v. Workers' Compensation Appeals Board (Wiggs) (Court of Appeal, published) 84 C.C.C. 367

Applicant, while employed as a hotel manager, sustained industrial injury to multiple body parts as a result of a specific injury dating back to 1997 and a cumulative trauma injury ending May 30, 1998, causing a need for medical treatment, including multiple surgeries. The parties entered into a stipulation in 2012, wherein they agreed to use a nurse case manager to evaluate applicant's home healthcare needs.

The WCJ ordered defendant to serve the nurse case manager with applicant's medical reports for a period spanning 2012 through 2016. The WCJ also ordered the nurse case manager to visit and interview applicant, and to issue a supplemental report on whether applicant needed home health care due to her industrial injuries and if so, to report on the frequency and duration of any such care. The board majority affirmed the Findings and Order.

Defendant filed a petition for writ of review. Defendant contended that the parties' dispute over applicant's need for home health care was governed by UR/IMR, and not by the 2012 stipulation.

The Court of Appeal agreed with defendant.

First, the Court of Appeal concluded that the Findings and Order issued by the WCJ and affirmed by the board was a "final order" for purposes of appellate review because it "cut right to

the heart of a jurisdictional issue," i.e., whether jurisdiction lies with "the UR process" or with "the WCJ and the appeals board" over the issue of home health care.

The Court of Appeal then held that substantial evidence did not support the board's conclusion that the parties had stipulated to a procedure for evaluating applicant's need for homecare by having Nurse Mefford report on the issue and there was no evidence of a change in applicant's condition or circumstances eliminating that need. Instead, the parties' 2012 stipulation was intended to be a one-time home assessment and report by Mefford.

Quoting SB 863 §1(e), and consistent with the Legislature's intent to have "medical professionals ultimately determine the necessity of requested treatment" and to further "the social policy of this state in reference to using evidence-based medicine to provide injured workers with the highest quality of medical care and independent medical review being necessary to implement that policy, the appeals board had no jurisdiction to review the medical necessity and reasonableness of home health care because there was no stipulation to displace the provision of home health care from the UR-IMR process."

In a footnote, the court also rejected defendant's April 30, 2019 request to dismiss the appeal (the parties apparently having settled their dispute over home health care). The court stated that once it issues an alternative writ or order to show cause, it may decide the case and issue a written decision even if the parties negotiate a settlement before oral argument, citing Glenfed Dev. Corp. v. Superior Court (Nat. Union Fire Ins. Co.) (1997) 53 Cal.App.4th 1113, 1116, fn. 1 ["a negotiated resolution of the issue on the eve of oral argument does not mean we will refrain from filing our opinion"].

The court's docket shows May 13, 2019 as the date oral argument was waived and the matter was submitted for decision; the court issued its opinion two days later.

4. Jurisdiction

Hollingsworth v. Superior Court of Los Angeles (Court of Appeal, published) 84 C.C.C. 718

Applicant was involved in a fatal accident while employed by Heavy Transport in June of 2016. Decedent's wife and son filed a wrongful death complaint in superior court on 1/22/18. They alleged that the employer did not have workers' compensation coverage. They also alleged that defective equipment contributed to the accident. Defendant alleged that they were part of Bragg Investment Company who held the workers' compensation coverage. On 3/5/18, Bragg and Heavy Transport demurred to the complaint alleging that Bragg had workers' compensation coverage so plaintiff was barred by workers' compensation exclusivity. On 3/14/18, defendants filed an application with the WCAB. The trial court overruled the demurrer because plaintiffs had alleged that the employer did not have workers' compensation coverage. In December 2018, the WCAB determined that the accident occurred in the course of decedent's employment. The WCAB set a hearing for 2/19/19 to determine if there was any insurance that covered the accident. Defendants asked that the civil case be stayed until the WCAB determined the insurance issue. The court granted defendants' request for a stay. The WCAB case was set for

arbitration on 6/6/19. Plaintiffs filed a preliminary injunction to preserve the court's jurisdiction. This was denied and a writ of mandate was filed by plaintiffs. The appellate court issued an order staying the WCAB proceedings and took oral argument.

They looked at the following question: "Which tribunal–the superior court or the WCAB–should resolve the question that will determine whether the superior court or the WCAB has exclusive jurisdiction over plaintiffs' claims?" They looked to the case of Scott v. I.A.C. (1956) 46 Cal.2d 76. In Scott, the court found that whichever tribunal exercised jurisdiction first should make the necessary finding to determine which tribunal had exclusive jurisdiction over the remainder of the matter. In fact, they found that the only point of concurrent jurisdiction of the two tribunals appears to be jurisdiction to determine jurisdiction. Stating "when two or more tribunals in this state have concurrent jurisdiction, the tribunal first assuming jurisdiction retains it to the exclusion of all other tribunals in which the action might have been initiated."

In this matter, the superior court exercised jurisdiction first. Plaintiffs' complaint was filed on 1/22/18 and defendants' WCAB application was filed on 3/14/18. Under Scott, the appropriate tribunal to determine the question of exclusive jurisdiction is the superior court, because the tribunal exercised jurisdiction first. The simple rule is the tribunal first assuming jurisdiction retrains it to determine the question of exclusive jurisdiction.

The superior court and the WCAB erred in their orders allowing the questions central to the exclusive jurisdiction to be determined by the WCAB instead of the superior court. The WCAB proceedings were stayed and the trial court was ordered to conduct further proceedings limited to determining which tribunal had exclusive jurisdiction over plaintiffs' claims. Costs were awarded.

5. Interpreters

Meadowbrook Insurance Company v. WCAB (Court of Appeal, published) 84 C.C.C. 1033

The interpreter provided Spanish-language interpreting services to two injured workers in connection with their medical care. The interpreter timely submitted invoices to the defendant, which in turn issued explanations of review (EORs) pursuant to Labor Code §4603.3, refusing to pay the invoice submitted. The interpreter objected to those EORs, but did not request a second review.

Although Cal. Code Reg., Title 8, §9795.3, which establishes an existing fee schedule for interpreter services, was amended to cover interpreter services at medical treatment appointments following the enactment of SB 863, a new fee schedule for interpreter services has not yet been adopted. Because of this, the WCAB has held that an interpreter lien claimant is not required to seek a second review and that disputes over interpreter fees are not subject to IBR.

The WCAB issued a decision in favor of the interpreter finding its liens were not barred by the failure to request a second review because the administrative director had not adopted a fee schedule pursuant to §4600(g).

The WCAB believed there was not an applicable fee schedule for the purposes of Reg. §9792.5.4 because a new one was not adopted for interpreter services after the enactment of SB 863.

Therefore, it concluded the interpreter's liens were not barred by its failure to request a second review or IBR. A petition for writ of review was filed with the appellate court.

The 3rd District Court of Appeal, in a decision reversing the WCAB's decision, held that an interpreter's failure to comply with the required procedures results in its bills being deemed satisfied, meaning a defendant is not liable for further payment.

The 3rd District Court of Appeal annulled the WCAB's decision. The court found no statute requires a fee schedule to be adopted after the enactment of SB 863 and that Reg. §9795.3 established an applicable fee schedule for interpreter services.

The court explained that while the fee schedule established by Reg. §9795.3 was not as detailed as other fee schedules, there was no authority defining the level of detail required by a fee schedule or holding that a less detailed fee schedule does not qualify.

The court explained that because there was an applicable fee schedule, and the only remaining dispute was regarding the amount of payment, the interpreter was required to request a second review within 90 days of service of the EOR.

The court requires interpreters, and medical treatment providers generally, to request a second review within 90 days of an EOR if the only dispute is the amount to be paid. Otherwise, pursuant to §4603.2(e)(2), the bill is deemed satisfied.

The court concluded the interpreter's liens were barred by its failure to request a second review and IBR pursuant to §4603.2(e)(2). It also concluded the WCAB lacked jurisdiction to hear the parties' dispute.

6. Coverage

California Insurance Guarantee Association v. San Diego County Schools Risk Management Joint Powers Authority (Court of Appeal, published) 84 C.C.C. 957

Applicant filed a claim form in March listing tendonitis in her right elbow and carpal tunnel syndrome in her right wrist, from "repeated use over a long period of time 1995-2003." She submitted another claim form indicating she had suffered an injury on May 6, 2003, in her "right upper extremity−neck" from driving a bus. As Knowles (applicant) would later explain, May 6 was simply the date she reported the pain to her supervisor, not the date of any specific workplace injury. Medical reports consistently stated applicant had pain from "repetitive overuse." On September 3, 2004, applicant filed an Application for Adjudication before the WCAB. In its July 2005 answer, the District accepted her right elbow injury but disputed injuries to her neck and upper extremities. It also disagreed she was injured on May 6, 2003, stating applicant had instead suffered a CT. In July 2011, the parties stipulated that applicant suffered a "specific injury" on May 6, 2003, to her shoulder, wrist, upper extremities, and neck.

The District is a lawfully self-insured employer under the workers' compensation scheme. It is a member of JPA, which administers a self-insurance program for workers' compensation claims involving its members. JPA, in turn, opted to purchase excess workers' compensation insurance. The District is an additional insured on JPA's excess insurance policies.

After the WCAB award, JPA sought reimbursement from its excess carrier, Kemper. Kemper's policy covered JPA from July 2002 to July 2003, meaning it was in effect on the May 6, 2003 stipulated specific injury date. (JPA previously satisfied the self-insured retention of $100,000 on the Kemper policy.) Kemper made payments totaling $207,908 until 2013, when it became insolvent.

JPA then turned to insolvency insurer CIGA for reimbursement. CIGA denied coverage in May 2014, explaining there was no evidence applicant had suffered a specific injury. If her injury was found to be cumulative, CIGA believed that JPA could pursue other available insurance—namely, under the Swiss Re Group (Swiss Re) excess workers' compensation insurance policy that covered JPA from July 2003 to June 30, 2004. CIGA was joined as a party to the WCAB action until May 6, 2016. CIGA filed this action in superior court. It sought declaratory relief that JPA's reimbursement request is not a covered claim because applicant suffered a cumulative injury for which other insurance is available. Defendants filed motions for summary judgment on the complaint and cross-complaint. They argued the court lacked jurisdiction to determine applicant suffered a cumulative injury, as this fact had already been settled before the WCAB, and determining injury was within the WCAB's exclusive jurisdiction. The court ultimately entered judgment in defendants' favor on their cross-complaint, requiring CIGA to reimburse JPA $129,836.91 plus $3,335.87 in costs.

Central to CIGA's appeal is whether the superior court has jurisdiction to determine that applicant suffered a cumulative injury after the WCAB approved a stipulation that her injury was specific in nature.

Applicant is entitled to compensation pursuant to the award. CIGA's action cannot change that; it will resolve only whether it must indemnify the District and JPA for their benefit payments.

"As a creature of the Legislature, the [WCAB] has no powers beyond those conferred on it." (Victor Valley Transit Auth. v. Workers' Comp. Appeals Bd. (2000) 83 Cal.App.4th 1068, 1072 (Victor Valley).) The Workers' Compensation Act (WCA) gives the WCAB exclusive jurisdiction over proceedings "[f]or the recovery of [workers'] compensation, or concerning any right or liability arising out of or incidental thereto." The superior court and WCAB do not have concurrent jurisdiction over any given action—depending on the injuries claimed, one entity will lack jurisdiction to grant any relief whatsoever. (La Jolla, supra, 9 Cal.4th at p. 35.) "The only point of concurrent jurisdiction of the two tribunals is jurisdiction to determine jurisdiction; jurisdiction once determined is exclusive, not concurrent." (Ibid.) Relying on section 5300, the trial court concluded the WCAB had exclusive jurisdiction to determine that applicant suffered a cumulative, rather than specific, injury.

The court looked at "whether the alleged acts or motives that establish the elements of the cause of action fall outside the risks encompassed within the compensation bargain." Stating "Where

the acts are 'a "normal" part of the employment relationship' or workers' compensation claims process or where the motive behind these acts does not violate a 'fundamental' policy of this state then the cause of action is barred." By contrast, actions to recover economic or contract damages incurred independent of a workplace injury are not barred.

The question of whether a workers' compensation claim against a self-insured employer is covered by the employer's excess insurance policy is not a "normal" part of the . . . workers' compensation claims process. "CIGA's action can have no legal effect on applicant's ability to recover workers' compensation. As an excess insurer, Kemper was not obligated to provide compensation to applicant; it merely had a contractual obligation to indemnify JPA for certain claims. CIGA's action only determines who—as between the District/JPA, CIGA, and another excess insurer—bears the ultimate cost of the District's compensation obligation. Accordingly, it does not fall within the WCAB's exclusive jurisdiction. Courts have rejected exclusive WCAB jurisdiction where the action does not implicate the payment of benefits to the injured worker."

As has been explained in prior WCAB panels, although many self-insured employers purchase excess insurance, "excess insurance is not a method of securing compensation" pursuant to section 3700. Excess insurers do not assume primary and direct liability for the payment of compensation, whereas workers' compensation policies must contain a clause to that effect. Unlike workers' compensation insurers, excess insurers "may not be substituted for the self-insured employer as the sole entity that may be held liable under Labor Code section 3755." (*Millman v. Contra Costa County*, 2013 Cal.Wrk.Comp. P.D. Lexis 615)

Coverage dispute between a self-insured employer and its excess workers' compensation carrier is essentially a contract dispute between insurer and insured. (Millman) Such an action falls outside the compensation bargain and is not a part of the normal workers' compensation claims process. Accordingly, CIGA's action did not trigger exclusive jurisdiction of the WCAB pursuant to section 5300. An excess insurance policy is not a workers' compensation policy and therefore not subject to the workers' compensation scheme. The excess insurer, on the other hand, does not pay any workers' compensation benefits but rather reimburses the JPA after the JPA has paid those benefits." (Liberty, supra, 339 F.Supp.3d at p. 1029.) Excess insurance is optional under the workers' compensation scheme. CIGA's action for declaratory relief is not subject to the WCA's exclusivity bar. The WCAB's exclusive jurisdiction over actions involving "the recovery of compensation, or concerning any right or liability arising out of or incidental thereto" (§5300) does not extend to contract-based disputes between a self-insured employer and its excess carrier (or that carrier's insolvency insurer). The court is not without jurisdiction to make a factual determination that applicant suffered a cumulative injury, even if its finding contradicts a stipulated fact approved by the WCAB.

The judgment was reversed.

7. Medicare

California Insurance Guarantee Association v. Azar; C.M.S. (9th Cir.) 84 C.C.C. 894

The California Insurance Guarantee Association (CIGA) filed an appeal to the 9th Circuit after the district court found in favor of Medicare after Medicare paid for and demanded reimbursement from CIGA for medical expenses of certain individuals whose workers' compensation benefits CIGA was administering.

CIGA is a guarantee fund in which participation is mandatory for insurers. CIGA is an insolvency insurer that "provides a limited form of protection for the public, and not for the protection of insurers." CIGA does not assume responsibility for claims where there is any other insurance available and is thus "an insurer of last resort." The Medicare Act provides that when "payment has been made, or can reasonably be expected to be made…under a workmen's compensation law or plan" any payment by Medicare for the medical service "shall be conditioned on reimbursement." (42 U.S.C. Sec. 1395) Originally, Medicare was the primary payer of its beneficiaries medical costs, "even when such services were covered by other insurance." In the 1980s this changed, and Congress amended the act by expanding the situation in which Medicare was a secondary payer and giving Medicare ability to seek reimbursement from primary payers. The statute now forbids Medicare payments when a primary plan is reasonably expected to make payment for the same medical care. (U.S.C. Sec 1395). A workers' compensation plan would be deemed a primary plan.

In this case Medicare's administrator, the Center for Medicare Services (CMS) contends that CIGA is a primary payer of medical expenses related to work injuries, and demanded that CIGA reimburse CMS for conditional payment that CMS had made on the Medicare beneficiaries behalf. When the parties could not come to a resolution, CIGA filed suit seeking declaratory relief and injunctive relief. The district court determined that CMS was entitled to reimbursement for the conditional payments it had made because any contrary provisions in the Guarantee Act were preempted. Both sides appealed.

First the court looked at the provisions governing preemption. They quote 15 U.S.C. 1012 which states "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance." The court goes on to state that; "when the text of a pre-emption clause is susceptible of more than one plausible reading, courts ordinarily 'accept the reading that disfavors pre-emption."

The district court ruled that Medicare's secondary payer provisions applied to CIGA because they preempted the Guarantee Act. However, the analyses turned on the court's conclusion that CIGA is a "primary plan". Medicare regulations define "primary plan" to mean "in the context in which Medicare is the secondary payer, a group health plan or large group health plan, a workers' compensation law or plan, an automobile or laity insurance or plan, or no-fault insurance." (42 C.F.R. Sec. 411.21.) The appellate court determined that CIGA does not fall within the plain meaning of this definition because it is not a workers' compensation law or plan.

This distinction is reflected in California's two separate statutory schemes for workers' compensation and insurer insolvencies. It is also reflected in state court decisions distinguishing CIGA from a workers' compensation carrier. The court discussed the matter of CIGA v. WCAB 39 Cal. Rptr. 3d 721 where the court found that EDD was not entitled to reimbursement from CIGA on its lien which it would have been entitled to reimbursement when the employer's insurance company was solvent. EDD was not entitled to reimbursement from CIGA because CIGA's obligations are not coextensive with those of solvent insurers. CIGA is not a workers' compensation plan.

The court determined that the Medicare statute did not intend to disrupt state law governing insurer solvency. They looked to a 2003 amendment to the preemption provision stating "Congress clarified that the preemption provision did not apply to 'state law relating to plan solvency.' Insurance, the court notes, is a contract by which one party undertakes to indemnify another party against risk of loss, damage or liability…" "CIGA is an arrangement through which other California insureds provide health benefits or medical care for the insured illnesses, injury or loss when one of its member insurance companies becomes insolvent." CIGA is not a workers' compensation insurer.

The court found that because CIGA is not a primary plan under the Medicare Act's secondary payer provisions, it has no obligation to reimburse CMS for conditional payments made on behalf of workers' compensation insureds. The court reversed and remanded for further proceedings.

EN BANC AND SIGNIFICANT PANEL DECISIONS

8. Permanent disability

Wilson v. State of Ca. Cal. Fire (en banc) 84 C.C.C. 393

The applicant, a firefighter, was injured on May 13, 2014, when exposed to fumes and smoke while he was not wearing a breathing apparatus. The Qualified Medical Evaluator's reports, exclusive of the psychiatric disability, rated 66% permanent disability, which was found by the WCJ. The permanent disability excluded an impairment rating for applicant's psyche injury pursuant to §4660.1(c). Applicant filed a Petition for Reconsideration.

The applicant contended that the psychiatric rating should be included because the psychiatric injury was directly caused by events of employment and therefore §4660.1(c)(1) does not apply, because the injury was not a compensable consequence of a physical injury. In addition, applicant argued that he was entitled to the increased impairment rating for psychiatric injury, because the injury resulted from the applicant being a victim of violent act or is catastrophic pursuant to Labor Code 4660.1(c)(2)(A)-(B). The WCAB granted reconsideration.

The WCAB found that Labor Code §4660.1(c)(1) does not bar an employee from claiming a psychiatric injury or obtaining treatment or temporary disability for a psychiatric disorder that is a compensable consequence of the physical injury. Labor Code §4660.1(c)(1) does not apply to psychiatric injuries directly caused by actual events of employment. Section 4660.1(c)(1) only bars an increase in the employee's permanent impairment for psychiatric injury that is a compensable consequence of a physical injury.

The employee may receive an increased impairment rating for a compensable consequence of a psychiatric injury if the injury falls under one of the statutory exceptions outlined in §4660.1(c)(2). The exceptions are being a victim of a violent act or direct exposure to a significant violent act with the meaning of §3208.3 or a catastrophic injury, including but not limited to, loss of limb, paralysis, severe burn or severe head injury

In order to receive an increased impairment rating, the applicant bears the burden of proving the psychiatric injury was directly caused by events of employment, or alternatively, if the psychiatric injury is a compensable consequence of the physical injury, applicant must show that the psychiatric injury resulted from either being the victim of a violent act or direct exposure to a significant violent act or catastrophic injury.

Section 4660.1(c)(2)(B) does not define catastrophic injury, although the statute specifies that it includes but is not limited to certain injuries: loss of limb, paralysis, severe burn or severe head injury.

The statutory language addressing a catastrophic injury identifies four examples. The word "catastrophic" is an adjective. The focus in this section is consequence of the nature of the injury, rather than on the mechanism of the injury. This is illustrated by the specific types of injuries identified in the statute since they all focus on the result of the injury: loss of a limb, paralysis, severe burn and a severe head injury represent particular results from an injury.

Because the phrase "catastrophic injury" was considered ambiguous by the appeals board, they turned to extrinsic sources to select the construction that comported most closely with the apparent intent of the Legislature, with a view to promoting rather than defeating the general purpose of the statute, and avoid an interpretation that would lead to absurd consequences.

The appeals board then went through the legislative history and indicated that the history reflects that the legislative purpose in enacting §4660.1(c) was to limit additional impairment for psychiatric injuries for questionable claims of disability and to reduce the amount of litigation around permanent disability ratings. By carving out exceptions to the proscription against an increased rating for psychiatric injury, the Legislature indicated that certain mechanisms and types of injury warrant permitting additional impairment under specific circumstances. The appeals board then turned to other statutory definitions of catastrophic injury in California law.

The section does not state a minimum level of permanent disability at which an employee may be deemed to have sustained a catastrophic injury. In creating an exception, the Legislature could have defined the phrase as an injury resulting in a minimum level of permanent disability. Since the Legislature did not do so the board indicated they would not define catastrophic injury as an

injury causing a minimum level of permanent disability. The board then indicated that their review of extrinsic sources did not provide them with a clear definition of catastrophic injury in interpreting the section. However, based on their analysis, the appeals board concluded the statutory language of §4660.1(c)(2)(B) focuses on the nature of the injury as reflected in the statutory examples included in the section by the Legislature. The determination of whether injury is catastrophic will be a fact-driven inquiry.

The statute reflects that the psychiatric injury must result from a catastrophic injury in order for an employee to receive an increased rating for the psychiatric injury. This indicates that the inquiry into whether an injury is catastrophic is limited to looking solely at the physical injury, without consideration for the psychiatric injury in evaluating the nature of the injury. The injury must therefore be deemed catastrophic independent of the psychiatric injury.

Although the focus in determining whether an injury is catastrophic is on the physical injury, the employee must prove the psychiatric injury was predominantly caused by actual events of employment in order to receive an increased impairment rating.

The nature of the injury sustained is a question of fact for the WCJ. After considering all the medical evidence and other documentary and testimonial evidence of record, the WCJ must determine whether the injury is catastrophic under the section. The trier of fact may consider the following factors in determining whether an injury may be deemed catastrophic:

1. The intensity and seriousness of treatment received by the employee that was reasonably required to cure or relieve from the effects of the injury.
2. The ultimate outcome when the employee's physical injury is permanent and stationary.
3. The severity of the physical injury and its impact on the employee's ability to perform activities of daily living.
4. Whether the physical injury is closely analogous to one of the injuries specified in the statute: loss of limb, paralysis, severe burn or severe head injury.
5. If the injury is an incurable and progressive disease.

Not all of these factors may be relevant in every case and the employee need not prove all these factors apply in order to prove a catastrophic injury. The list is also not exhaustive and the trier of fact may consider other relevant factors regarding the physical injury. Applying the test to this case, the appeals board concluded applicant's injury was catastrophic.

The board indicated the evidence reflected the initial treatment was serious and life-threatening. Applicant presented to the hospital with multiple symptoms in several body parts including fever, nausea, vomiting, a full body rash, bilateral eye discharge, difficulty breathing as well as ulcers on his mouth and throat. He was placed in a medically induced coma and suffered both renal and respiratory failure. During his hospitalization he also suffered from tremors. The physical injury caused 66% permanent disability rating. The medical reporting shows the applicant continues to suffer from the effects of his injury and that there is a substantial impact on his ability to perform activities of daily living.

The evidence therefore supports that the intensive treatment and lasting impact of the injury on the applicant resulted in a catastrophic injury.

Reconsideration was granted and the award was rescinded. The WCAB issued a new findings and award that, among other issues, found a catastrophic injury and remanded for a determination of the permanent disability.

9. Medical-legal

Colamonico v. Secure Transportation (en banc) 84 Cal. Comp. Cases 1059

The parties stipulated that the applicant, while employed from January 1, 2013 through April 15, 2013, as a bus driver for defendant, claimed injury arising out of and occurring in the course of her employment to her spine and internal organs.

Between April 15, 2014 and June 25, 2015, applicant requested lien claimant's copy service to obtain records at multiple locations. Lien claimant issued several subpoenas duces tecum. Lien claimant issued numerous invoices for its copy services to defendant. Defendant issued eight explanations of review (EOR) for lien claimant's copy services.

The matter proceeded to trial on the issues regarding lien claimant's lien, necessity and value of the copy service as well as penalties and interest.

The WCJ issued a Findings and Order which found as follows: (1) defendant waived all objections to the unpaid portion of the medical-legal photo copy billings; (2) lien claimant was entitled to reimbursement of the sum of $1,151.07 as well as penalty and interest; and (3) lien claimant was entitled to the penalty and interest on its invoices for copy services between August 31, 2015 and November 2, 2015, which defendant paid in full but not within 60 days of receipt of said invoice. Defendant filed a Petition for Reconsideration.

The WCAB ruled that a medical-legal provider has the initial burden of proof that it complied with Labor Code §4620 and §4621. Section 4622 provides the framework for reimbursement of medical-legal expenses. Subsection (f) of that statute, however, specifically states that this section is not applicable unless there has been compliance with sections 4620 and 4621. Section 4620(a) defines a medical-legal expense as a cost or expense that a party incurs for the purpose of proving or disproving a contested claim. Copy service fees are considered medical-legal expenses under §4620(a).

Lien claimant's initial burden in proving entitlement to reimbursement for a medical-legal expense is to show that a contested claim existed at the time the service was performed. Subsection (b) sets forth the parameters for determining whether a contested claim existed.

Essentially, there is a contested claim when: (1) the employer knows or reasonably should have known of an employee's claim for workers' compensation benefits; and (2) the employer denies the employee's claim or fails to act within a reasonable time regarding the claim.

The issue of whether a purported medical-legal expense involves a contested claim is a fact-driven inquiry. The public policy favoring liberal pre-trial discovery that may reasonably lead to

relevant admissible evidence is applicable in workers' compensation cases. Thus, parties generally have broad discretion in seeking and obtaining documents with the subpoena duces tecum in workers' compensation cases.

Assuming a lien claimant has met its burden of proof pursuant to §4620(a), it has a second hurdle to overcome; the purported medical-legal expense must be reasonably, actually and necessarily incurred. The determination of the reasonableness and necessity of a service focuses on the time when the service was actually performed.

A lien claimant holds the burden of proof to establish all elements necessary to establish its entitlement to payment for a medical-legal expense. Thus, a lien claimant is required to establish that (1) a contested claim existed at the time the expenses were incurred; (2) the expenses were incurred for the purpose of proving or disproving the contested claim; and (3) the expenses were reasonable and necessary at the time they were incurred. Once a lien claimant has established these three elements, it may proceed to address the reasonable value of its services under §4622.

In sum, §4620 and §4621 pertain to a medical-legal provider service, and §4622 pertains to the reasonable value of the services.

Defendant does not waive an objection based on §4620 or §4621 for failing to raise the objection in an explanation of review in accordance with §4622. Section 4622, which provides that an employer/carrier must protest a medical-legal billing within 60 days of receipt, has no application in its entirety when the medical legal provider has not complied with the contested claim rule, because the legislature so provided in Labor Code §4622(d).

The appeals board found that the contested claim rule found in Labor Code §4620 applies equally to the reasonableness and necessity requirement found in §4621. The Legislature's inclusion of Labor Code §4621 when it amended former Labor Code §4622(d) reflects that compliance with both sections is necessary before §4622 is applicable.

In this case, the WCJ found the defendant waived its Labor Code §4620 and §4621 objections by failing to timely issue explanations of review.

The WCAB said the WCJ's analysis was inconsistent with §4622(f) and inconsistent with Rule 10451.1(f)(1)(A), which specifically states that defendant shall be deemed to have finally waived all objections to a medical-legal provider's billing, other than compliance with Labor Code §4620 and §4621 for failure to respond to a provider's billing as required.

The defendant did not therefore waive its objections based on Labor Code §4620 and §4621 for failing to raise these objections in the EOR.

Therefore, in this matter, lien claimant had the initial burden of proof that it complied with §4621(a). The record was found not sufficiently developed for the Board to render a decision on the merits of this particular issue.

The WCAB indicated they were aware that a defendant may challenge the reasonableness and or necessity of a medical-legal expense for the first time in a lien conference without first objecting

in an EOR. Should a defendant pursue this type of litigation strategy, a defendant potentially could expose itself to penalties and interest retroactive to receipt of the date of the bill.

Furthermore, if the defendant failed to communicate these objections to a lien claimant before the lien conference, the WCJ has discretion to consider whether the defendant is pursuing bad-faith tactics to delay the resolution of the lien. Any bad-faith action or tactic may be a basis for potential sanctions pursuant to Labor Code §5813.

In sum, the board stated that in this matter lien claimant has a burden of proof that services were reasonable and necessary at the time they were incurred pursuant to §4621(a) and defendant did not waive this objection by failing to address this issue in an EOR in accordance with §4622.

The WCAB rescinded the findings and award and returned the matter to the trial level.

10. Stay

Villanueva v. Teva Foods (SPD) 84 C.C.C. 198

The appeals board held that Labor Code §4615(a) requires that in order for a lien of an entity to be subject to the automatic stay on the filing of criminal charges as described in Labor Code §139.21(a)(1)(A), the entity must be controlled by a physician, practitioner or provider charged with such a crime.

Pursuant to Labor Code §139.21(a)(3), an entity is "controlled" by a physician, practitioner or provider charged with a crime as defined in Labor Code §139.21(a)(1)(A) if that physician, practitioner or provider is an officer or a director of the entity or a shareholder with a 10% or greater interest in the entity. Control pursuant to Labor Code 139.21(a)(3) may be established with admissible evidence that the physician, practitioner or provider is or was an officer or director of the entity, is or was a shareholder with a 10% or greater interest in the entity or, held de facto ownership of the entity or de facto control consistent with the rights and duties of an officer or director of the entity.

The appeals board in upholding the trial judge's determination found that the lien claims of Firstline Health were subject to a Labor Code §4615 stay because the available evidence showed the entity was either currently or previously controlled by a person criminally charged under Labor Code §139.21(a)(3) or potentially liable for de facto insurance fraud.

The appeals board reviewed contrary evidence purported to establish that another doctor was the sole owner and officer, but the sworn declaration of an indicted potential co-conspirator persuaded the appeals board that it was a criminally-charged doctor who had exercised, and continued to exercise control over the entity.

Since the declaration was served immediately before the trial, due process required that the lien claimant be given the opportunity to call and cross-examine witnesses and offer rebuttal evidence. Therefore, the case was remanded for that purpose.

The appeals board indicated that the party seeking the stay bore the burden to show that lien claimant was subject to the provisions of Labor Code §4615 and §139.21 and concluded that

defendant had likely submitted sufficient admissible evidence to establish a prime facie case for a Labor Code §4615 lien stay. The appeals board indicated the statement was admissible and the evidence of lien claimant did not rebut declarant's statement which specifically addressed significant fraudulent activity, including the backdating of legal documents to create the appearance of an earlier transfer.

11. Timelines

Pa'u v. Department of Forestry/Cal Fire (SPD) 84 C.C.C. 815

Applicant sought reconsideration of the Findings, Award and Order that issued on May 31, 2018, wherein the WCJ found in pertinent part that defendant timely denied applicant's requests for treatment via Utilization Review (UR). Applicant contended that the UR denials were untimely because Saturday is a working day for purposes of Labor Code §4610, and therefore that the Workers' Compensation Appeals Board (WCAB) has jurisdiction over the dispute and that the WCJ should have awarded applicant the requested treatment.

The WCAB concluded that although Saturday is a business day under Civil Code §9, it is not a working day under Labor Code §4610, because Labor Code §4610 does not incorporate the definition of business day found in Civil Code §9.

Applying the principles of statutory interpretation, the WCAB determined that the phrase "working day" found in Labor Code §4610 does not include Saturdays based upon its standard modern usage, as reflected in dictionary definitions, statutory and regulatory enactments and judicial decisions. Moreover, even if Saturday were a working day, the UR decisions in this case would still be timely based upon Code of Civil Procedure §12a, which extends the deadline for performance of acts that fall due on a Saturday.

The Legislature enacted SB 537, which amended Labor Code 4600.4(b) to state that a "normal business day" does not include Saturday, Sunday or any day that is declared by the Governor to be an official state holiday or a holiday listed on the Department of Human Resources website.

WRIT DENIED CASES

12. PQME

City of Tracy v. Workers' Compensation Appeals Board (Luckhardt) (W/D) 84 C.C.C. 838

Applicant sustained injury to his right shoulder on 10/18/15 while employed by the City of Tracy. While applicant was unrepresented he obtain a QME panel issued by the medical unit in the specialty of orthopedics. Applicant, after becoming represented by an attorney, switched his primary treating doctor to a pain management specialist and requested a replacement QME panel

in pain management. Defendant argued that applicant was not entitled to a change in specialty. The medical unit issued a new orthopedic panel.

On 3/19/18, applicant's attorney again requested a replacement panel in pain management. The medical unit issued a replacement panel in pain management. Defendant objected. The matter proceeded to trial.

The judge found that applicant obtained a valid QME panel in pain management under *Romero v. Costco Wholesale* (2007) 72 C.C.C. 824. The judge found that the applicant's letter to the medical unit constituted an objection to the orthopedic panel and that applicant "substantially" complied with the procedure to request a change in specialty even if applicant did not fully comply with the rule. Defendant filed a petition for removal. Defendant argued that applicant could not unilaterally change the QME panel specialty, that the change in specialty was not based on substantial compliance with the regulations, and that the WCJ did not have jurisdiction to address the panel specialty dispute and that defendant was denied due process.

In denying removal the WCAB explained that applicant was permitted to obtain a QME panel in pain management after becoming represented by an attorney. Labor Code §4062.1 provides the procedure for unrepresented workers to obtain a QME panel, whereas the procedure for represented workers to obtain a QME panel is set forth in Labor Code §4062.2. In Romero, the WCAB analyzed the application of Labor Code §§4062.1 and 4062.2 in a situation very similar to the one at hand, when the employee was unrepresented when a QME panel was issued but became represented before receiving an evaluation by a physician from the panel. The WCAB in that case held that the employee was entitled to replace the previously issued orthopedic panel with a chiropractic panel when she changed from being unrepresented to being represented because she had never actually undergone the evaluation with the orthopedic QME. Applicant in the instant matter never "received" a comprehensive medical-legal evaluation from the original orthopedic QME, because no evaluation was conducted with a physician from the orthopedic panel.

In reaching its conclusion, the WCAB clarified that applicant's request for a panel in pain management was for a new panel under Labor Code §4062.2 and not for a replacement panel. Accordingly, the WCAB found that applicant was not obligated to comply with the regulations governing replacement panel requests. Further the WCAB denied defendant's claim that it was denied due process. Defendant filed a petition for writ of review which was denied.

13. Apportionment

Nieves v. Workers' Compensation Appeals Board (W/D) 84 C.C.C. 221

Applicant suffered a continuous trauma injury to his left ankle, low back, neck, right shoulder, right elbow, right hand and hernia. Applicant had a prior industrial injury to his left ankle and lumbar spine for which he received a stipulated award of 31%. The parties utilized the Agreed Medical Evaluators in orthopedics and internal medicine.

The orthopedic AME provided a 9% WPI for the right shoulder, 7% WPI for the cervical spine, 7% for the right elbow, wrist and hand and the internist gave a 20% WPI for the hernia. Both physicians found no basis for apportionment.

The WCJ found a 47% permanent disability after apportionment. The WCJ determined that 50% of applicant's PD was apportionable pursuant to Labor Code §4664(b) to the prior award of 15% PD.

Although the applicant alleged that, based on the report of his vocational expert, the applicant was 100% permanently disabled, the WCJ determined that the report was not substantial evidence because the physician erroneously combined the impairments from the 2001 injury with those of the 2012 and also incorrectly assumed applicant had medical restrictions that limited him to sedentary work. Applicant filed a Petition for Reconsideration. The WCAB granted reconsideration and in a split panel decision affirmed the WCJ's finding regarding level of permanent disability.

The WCAB found that the WCJ followed the AME's opinion and that there was no basis for apportionment of PD to prior nonindustrial factors. Nevertheless, the WCJ found jurisdiction for apportionment to applicant's prior award pursuant to the presumption in Labor Code §4664(b). When there has been a prior award of PD, it is conclusively presumed that the prior award exists at the time of any subsequent industrial injury.

The WCAB observed that the Labor Code §4664(b) presumption is one affecting the burden of proof and that, as held in *Kopping*, for apportionment to apply under this section the defendant must prove both the existence of a prior award and overlap of the permanent disability caused by the two injuries. In this case, the WCAB believed that the physician's opinion regarding applicant's risk factors for suffering further hernias after having had prior hernias and related surgery supported apportionment under Labor Code §4664(b).

The appeals board found the presence of overlap is evidenced by the risk factors of prior hernias and prior surgical procedures as opinion by the physician. They found the apportionment was proper pursuant to Labor Code §4664(b).

Finally, the WCAB found that the reporting of the vocational expert failed to establish that applicant was not amenable to vocational rehabilitation and for that reason did not rebut the schedule PD rating pursuant to the principles in Ogilvie, LeBouef and Dahl.

Dissenting commissioner Sweeney indicated she believed it was appropriate to rescind the determination and return the matter to the trial level for further consideration whether applicant had a total loss of future earning capacity.

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

14. Penalties

Pena v. Workers' Compensation Appeals Board (W/D) 84 C.C.C. 527

Defendants disputed liability for applicant's psychiatric injury but admitted all other body parts.

The matter proceeded to trial and the applicant was awarded future medical care for his physical injuries. Applicant's psychiatric injury was not an issue at the trial. After the original award issued, applicant was diagnosed with a psychiatric disorder and requested authorization for treatment.

Applicant claimed the defendant unreasonably delayed provision of the requested treatment and the matter proceeded to trial on the issue of psychiatric injury and applicant's entitlement to penalties for defendant's failure to provide medical care for the psychiatric injury and liability for attorney's fees.

The WCJ did not make a specific finding of fact as to whether the applicant suffered a psychiatric injury, but he did indicate in the Opinion on Decision that he found a compensable psychiatric injury. The WCJ also awarded a penalty for unreasonable delay in failing to authorize the psychiatric treatment and a 25% penalty pursuant to Labor Code §5814 for attorney's fees under Labor Code §5814.5. Defendant filed a Petition for Reconsideration only on the issue of penalties and attorney's fees. The WCAB granted reconsideration and upheld the award of penalties under Labor Code §5814. However, in a split decision, the WCAB rescinded the award of attorney's fees.

The WCAB majority explained that Labor Code §5814.5 provides that when payment of compensation has been unreasonably delayed or refused subsequent to the issuance of an award, the WCAB shall award reasonable attorney's fees incurred in enforcing the payment of compensation awarded.

In the case of *Ramirez* (73 C.C.C. 1234 en banc) the WCAB interpreted Labor Code §5814.5 and found that attorney's fees under this provision should be allowed only for services rendered to enforce an unreasonably delayed prior award.

In the instant case, the appeals board pointed out the issue of psychiatric injury and need for treatment to the psyche was not raised at the time the prior award issued. Consequently, the second trial, which addressed applicant psychiatric claim, was not conducted to enforce an award, and the WCJ's award of attorney's fees was contrary to Labor Code §5814.5 and the *Ramirez* decision. *Ramirez* provides that a fee under §5814.5 is only payable when there is a prior award of benefits, there is an unreasonable delay in the payment of some or all of that award and the applicant has incurred attorney's fees enforcing the prior award.

The dissenting Commissioner opined that she believed §5814.5 allows an award of reasonable attorney's fees for defendant's unreasonable delay after any prior award has been made, whether or not that particular delayed item was within the specie of benefits previously awarded.

The writ was denied.

15. Presumption

Khachatrian v. State of California Attorney General's Office (BPD) 84 C.C.C. 543

The WCJ issued Findings of Fact wherein it was found that the Labor Code §5402 presumption of compensability does apply to the Labor Code §3208.3(h) defense of lawful, non-discriminatory good faith personnel action and that any evidence of witnesses that could have been obtained with reasonable diligence within 90 days of the filing of the claim shall be excluded. The Workers' Compensation Appeals Board granted reconsideration for study and then issued an Opinion and Decision after Reconsideration.

The appeals board indicated that the parties stipulated that defendant did not deny liability for the claimed injury within 90 days of defendant's receipt of applicant's DWC-1 claim form. The defendants argued that applicant's injury was substantially caused by lawful, nondiscriminatory personnel actions and that Labor Code §3208.3(h) falls outside the scope of the Labor Code §5402(b) presumption.

The appeals board rescinded the Findings of Fact and returned the matter to the trial level so that defendant may try the good faith personnel action defense utilizing all competent evidence, regardless of whether it could have been reasonably obtained within 90-days of receipt of the DWC-1 claim form. The appeals board held the evidence of good faith personnel action defense is exempt from Labor Code 5402 §(b) presumption.

The appeals board cite the case of *James v. WCAB* (62 C.C.C. 757), in which the Court of Appeal held that the provisions of Labor Code §5402 do not apply to employees' claims of psychiatric injuries who have been employed for less than six months, where the injury is not caused by sudden and extra and extraordinary employment incident.

Thus, the *James* court held that even in cases where the §5402(b) presumption would otherwise apply, a defendant may still prove that applicant was employed for less than six months and the injury was not caused by a sudden and extraordinary employment incident, even if the evidence could have been reasonably obtained within 90-days of the filing of a claim form.

The *James* court held that the "notwithstanding any other provision" phrase in subdivision (d) as overriding other statutes in the Labor Code, including Labor Code §5402(b). Thus, notwithstanding any other provision, including §5402(b), psychiatric injuries occurring the first six months of employment are not compensable.

Noting the similarity between the opening phrase of §3208.3(d) and subdivision (h) that no compensation under this subdivision shall be paid if the injury was substantially caused by a lawful, nondiscriminatory, good-faith personnel action, the appeals board followed the *James* court's reasoning in they concluded when a psychiatric injury is presumed compensable under a

§5402(b), defendant is not precluded from asserting and presenting evidence on the good faith personnel action defense under §3208.3(h), regardless of when evidence was reasonably obtainable.

This conclusion is consistent with the legislative intent of §3208.3 as described in subdivision (c), which is to establish a new and higher threshold of compensability for psychiatric injuries under this division. Division IV of the Labor Code includes both §3208.3 and §5402.

The appeals board also cited the case of *Insalo v. WCAB* (Writ Denied) (64 C.C.C. 1407) and the recent *Carrasco v. Department of Corrections* (BPD) (2018 Cal. Wrk. Comp. P.D. LEXIS 398) in which it was held that §5402(b) does not preclude evidence supporting the good faith personnel action defense, regardless of when the evidence was attainable. The appeals board agreed with both those cases and rescinded the decision and returned the matter to the trial level for a new decision, including but not limited to further development of the record and a determination on the merits of the good faith personnel action defense under §3208.3(h).

The appeals board further stated that other than their conclusion that the presumption of compensability of the psychiatric injury under §5402 does not preclude defendant from asserting and presenting evidence on the good faith personnel action defense, the Appeals Board expressed no final opinion on any substantive issue.

16. Interpreters

Mendez Sanchez v. Hartmark Cabinet Design (BPD) 47 CWCR 31

Applicant filed a specific injury claim which was settled. According to the settlement documents, an interpreter was present and assisted in translating the settlement to the applicant, presumably at applicant's attorney's office. A WCJ issued an Order Approving the Compromise and Release. Applicant's attorney, after approval of the settlement, filed a petition for costs related to the interpreter services. The WCJ denied the petition stating that because the services did not occur at a hearing or deposition, defendant was not liable for the costs. The interpreter filed a Petition for Reconsideration.

The appeals board indicated that Labor Code §5811 mandates defense payment of qualified interpreter fees that are reasonably, actually and necessarily incurred.

The statute expressly allows payment for services performed at a deposition, an appeals board hearing or a medical treatment or medical legal evaluation. The section also allows payment for interpreting service during those settings which the administrative director determines are reasonable and necessary to ascertain the validity or extent of injury to an employee who does not speak English proficiently.

The appeals board stated AD Rule 9795.3, that interpreting services shall be paid for in a large list of settings: participating in depositions and deposition preparation, reading of a deposition transcript, attending appeals board hearings, arbitrations and other similar settings determined by the WCAB to be reasonable and necessary to determine the validity and extent of injury to an employee.

The Compromise and Release in the present case, the appeals board noted, settled applicant's entitlement to all future workers' compensation benefits, including TD, PD and medical treatment. The settlement further certified that by signing the agreement, the applicant had acknowledged reading and understanding the agreement and that all questions were asked and answered to the applicant's satisfaction.

The appeals board agreed with the WCJ that interpreting services related to a Compromise and Release executed at an applicant's attorney's office did not expressly fit any category specified in Labor Code §5811, but reasoned that the general discretionary language in the statute and the rule justifies payment in this case.

The panel cited the reasonable and necessary standard indicating that discretion should extend to the Compromise and Release transactions, given the overall importance of the Compromise and Release in workers' compensation proceedings.

The panel stated that the burden to show that the interpreting service costs were appropriate required that the interpreter prove the services were in fact provided, they were necessary and the billing was proper.

The appeals board rescinded the WCJ's finding and returned the matter to the trial level for further proceedings on whether the fees for interpreting services were reasonably incurred and proper for payment.

17. Procedure

Martinez v. Consolidated Partitions (BPD) 2019 Cal. Wrk. Comp. P.D. LEXIS 415

In this case, the WCAB addressed what is referred to as a "Hybrid Decision." The WCAB opined that a decision that involved resolution of threshold issues is a final decision subject to a petition for reconsideration. In the alternative, non-final decisions may be challenged by a petition for removal. However, decisions that address a hybrid of both threshold and interlocutory issues would be deemed a hybrid decision. If a party challenges a hybrid decision, the petition would be treated as a petition for reconsideration because it involves a threshold issue. However, if the petitioner is challenging only the interlocutory issues, then the appeals board will evaluate the issues raised under the removal standard applicable to non-final decisions.

In this case, the decision involved both final and interlocutory findings. However, petitioner only challenged the interlocutory finding in the decision. Therefore, the finding/order is only subject to the removal standard and not the reconsideration standard. Removal is an extraordinary remedy rarely exercised by the appeals board. The appeals board will grant removal only if the petitioner shows that significant prejudice or irreparable harm will result if removal is not granted. In this matter none was shown and therefore the appeals board dismissed the petition for removal and denied the petition for reconsideration.

18. Labor Code Section 4605

Davis v. City of Modesto (BPD) 47 CWCR 8

The Court of Appeal vacated the board's dismissal of applicant's reconsideration petition and remitted the matter to the appeals board for determination of the applicability of Labor Code §4605 on the admissibility of the report both as evidence and for review by the parties' QME. The reason for the remittitur was that Labor Code §4605 was not considered by either the WCJ or the appeals board.

The appeals board stated that when an applicant is represented by an attorney, a comprehensive medical evaluation shall be obtained as provided in §§4060-4062, 4062.1 and 4062.2. By contrast, Labor Code §4605 clarifies that applicant has a right to provide, at his or her own expense, a consulting or attending physician. Reports prepared by these doctors are required to be reviewed by a qualified medical evaluator or authorized treating physician.

Further, the panel observed that Labor Code §4064(d) states that no party is prohibited from obtaining any medical evaluation or consultation at the party's own expense, and that such comprehensive medical evaluation shall be admissible in any proceedings before the appeals board. In *Valdez v. WCAB* (78 C.C.C. 1209), the Supreme Court determined that the apparent exclusivity of medical evaluations contained in the express provisions of Labor Code §§4060-4062 and 4062.1 and 4062.2 were procedural, and nothing about whether the reports obtained outside those sections are admissible. The *Valdez* court envisioned an expansive rather than limiting approach regarding the admissibility of medical evidence.

Furthermore, pursuant to Labor Code §4605, it was held those reports may form some of the basis for an award, but may not be the sole basis for an award.

The Court of Appeal in *Batten v. WCAB* (80 C.C.C. 1256) refined *Valdez*, holding that Labor Code §4605 permits the reports of consulting or attending physicians, but does not permit the admission of a report by an expert who was retained solely for the purpose of rebutting the opinion of a panel Qualified Medical Evaluator.

In the present case, the panel concluded that the admissibility under Labor Code §4605 and *Batten* hinged on whether the report was obtained solely for the purpose of rebutting a regularly obtain QME's opinion. If indeed the report was obtained solely as a rebuttal it is inadmissible.

Further, Rule 35(e) provides that in no event shall any party forward to the evaluator: (1) any medical/legal report which has been rejected by a party as untimely pursuant to Labor Code §4062.5; (2) any evaluation or consulting report written by any physician other than a treating physician, the primary treating physician or secondary physician, or an evaluator through the medical-legal process in Labor Code §§4060-4062, that addresses permanent impairment, permanent disability or apportionment under California workers' compensation laws, unless that physician's report has first been ruled admissible by a WCJ; or (3) any medical report or record or other information or thing which has been stricken, or found inadequate or inadmissible by a WCJ, or which otherwise has been deemed inadmissible to the evaluator as a matter of law.

The appeals board remanded the matter to the trial level for further determination as to whether the report fell within the provisions of Labor Code 4605 or was inadmissible under *Batten*.

19. QME

Depeters v. Frito Lay/Ace American (BPD) 47 CWCR 29

Applicant alleged in a claim form dated November 21, 2016, that he sustained an injury on November 12, 2016 in the form of nervous system disorder, stress and a heart attack, while working as a route sales representative for the employer. No Application for Adjudication of Claim was filed at that time.

In May 2017, a Qualified Medical Evaluator chosen from a panel reported the applicant had not suffered a specific injury and commented that he had not suffered a cumulative trauma injury on an industrial basis, although the applicant had not alleged a continuous trauma at that time.

On November 8, 2017, applicant's attorney filed two applications, one for specific injury occurring on November 12, 2016 and another for a cumulative injury occurring through November 12, 2016 to the same body parts. The issue that was litigated was whether the applicant was entitled to a different panel QME to evaluate the cumulative injury claim.

Defendant requested a finding on whether or not the applicant's original claim form submitted on November 21, 2016 alleged a specific or a cumulative date of injury.

The WCJ concluded that the applicant's claim form alleged a specific injury, but stated that his continuous trauma claim was for the same event as the specific injury claim and the applicant was not entitled to a new evaluator when he developed a different theory of causation. The WCJ ordered the applicant to return to the original Qualified Medical Evaluator regarding the subsequently pled CT claim. Applicant filed a Petition for Reconsideration.

The appeals board overturned the WCJ's decision, reasoning that in accordance with *Navarro* the applicant was entitled to a new QME panel to address the subsequently claimed cumulative injury

They observed that *Navarro* held that the Labor Code requires that an evaluator discuss all medical issues arising from all reported claims of injury at the time of an evaluation. Labor Code §4062.3(j) states that a medical evaluator shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employer's initial appointment with the medical evaluator.

Navarro also provides there is no provision in the Labor Code that requires an applicant to return to the same evaluator for a subsequent claim of injury even if the subsequent claim involves the same part of the body and same parties.

The panel rejected the WCJ's conclusion that an applicant may allege only one theory of causation and not allege multiple theories for the same industrial event, as well as the WCJ's assertion that the newly pled CT was a new medical issue and therefore not distinguishable from the facts and holding in *Navarro*. The panel concluded that because the applicant's cumulative

injury claim was made subsequent to the initial evaluation, it was not a claim that the QME could have addressed at the time of the evaluation.

The appeals board ordered the parties to proceed with the new evaluation with a new Qualified Medical Evaluator for the CT claim. The applicant was unrepresented when he filed his initial claim form alleging a specific injury causing a heart attack. Only after the PQME evaluation and the unfavorable result did the applicant obtain counsel who filed both the specific injury and a cumulative trauma injury claim.

20. Apportionment

Barnes v. City of Fullerton (BPD) 47 CWCR 5

Applicant, a police officer, sustained a low back injury in July 2004. He was not represented and did not then file a claim despite receiving notices of his right to seek workers' compensation benefits.

In September 2009, the applicant became represented and filed an application for a low back injury allegedly sustained on September 9, 2009, while on an uncompensated lunch break. Defendant denied the claim. The Qualified Medical Evaluator concluded the applicant originally injured his back in 2004 and exacerbated it on September 9, 2009.

The Qualified Medical Evaluator concluded the applicant had a 5% whole person impairment using DRE lumbar category two and concluded the disability resulted solely from the July 2004 injury. Defendant contended that the claim for the 2004 injury was barred by the Statute of Limitations.

As a compromise, applicant dismissed the 2009 application and the board approved the stipulation to zero PD for the 2004 injury. The stipulation stated the applicant sustained a back injury on that date with the right of future medical benefits. Applicant claimed another back injury on February 16, 2013 which occurred in a motor vehicle accident.

A new Qualified Medical Evaluator found an 8% whole person impairment and apportioned 50% to the 2004 injury, as exacerbated in 2009 without additional disability, and the remaining 50% to the 2013 injury. The matter proceeded to trial and the parties stipulated the applicant sustained injury to his lumbar spine on February 16, 2013, his overall permanent disability before apportionment was 18% and that they had previously stipulated that applicant's 2004 low back injury that resulted in an award of 0% PD.

The WCJ concluded that Labor Code §4664's conclusive presumption of disability from a prior award did not apply because there had been no such prior PD award and the Qualified Medical Evaluator had a properly apportioned 50% to each injury pursuant to labor code §4663.

Applicant filed a Petition for Reconsideration that he was entitled to a conclusive presumption of Labor Code §4664 and because the parties stipulated to a 0% PD award and none of the current disability could be apportioned to the 2004 injury.

The appeals board agreed that under Labor Code §4664(b), if applicant has a prior award of PD, it is conclusively presumed that the prior award exists at the time of any subsequent injury, and that, under *Kopping* (71 C.C.C. 1229), the presumption is not rebuttable. The panel agreed that the PD award from his 2004 industrial injury continued to exist at 0%.

However, the appeals board ruled that pursuant to *Brodie* (72 C.C.C. 565), Labor Code 4664(b) was intended to reverse the rule based on former Labor Code §4750 that permitted an injured employee to show rehabilitation of an injury for which permanent disability had already been awarded. As the court declared in *Kopping*, Labor Code §4664(b) simply prevents the claimant from defeating an employer's showing of apportionment by providing evidence of medical rehabilitation from a prior level of PD for which the worker already received PD benefits.

According to *Brodie*, the new approach to apportionment is to look at the current disability and parcel out its causative sources to nonindustrial factors of disability, prior industrial injuries, current industrial injuries and decide the amount directly caused by the current industrial injury. That approach requires consideration of past injuries and not to disregard those prior injuries. The Legislature intended to expand rather than narrow the scope of legally permissible apportionment.

Apportionment may also be established under Labor Code §4663(a) which provides that apportionment of PD shall be based on causation. Defendant's failure to prove overlap between prior and current disability under §4664(b) does not preclude apportionment under §4663.

The injured employee cannot prove medical rehabilitation to the show that he or she has less permanent disability than was previously awarded, and defendant may prove under §4663 that the injured employee's prior injury was now caused by more permanent disability than was previously awarded.

Further, if an injured employee had a prior PD award that is conclusively presumed to exist under Labor Code §4664(b), defendant may prove apportionment by showing the current disability duplicate or overlaps PD from the prior injury. The PQME established that before applicant's 2013 injury, he had demonstrated objective MRI evidence of spondylosis and lumbar disc protrusions. After the 2013 injury, the applicant still had those protrusions and evidence of spondylosis and now also had more disks protruding at different levels caused by the 2013 injury. Therefore, the apportionment provided by the Qualified Medical Evaluator was supported by the analysis of the medical record.

21. Labor Code §132(a)

Vaca v. Vons (BPD) 47 CWCR 129

Applicant sustained an industrially related injury to his right wrist on August 24, 2014.

Applicant was "singled out" in a crowded room of employees by a manager at the employer's wellness center. The manager told the applicant that he should probably "look for another job because he was always hurt," a statement applicant perceived as a direct threat to his job.

Later the same day, the employer suspended applicant, saying he had falsified a time sheet. Two months later, the employer terminated applicant's employment on grounds of claim discrepancy in a "sign-in" procedure, a violation of "company procedures," describing it as a theft of company time.

No witness, however, testified that applicant had not followed documented procedures to "punch" in at the beginning of the work shift, out for lunch, back in when returning from lunch, and out again when departing after the work day. The employer alleged the applicant had not met the additional requirement of signing in and out on a separate sheet of paper, but offered no documentary evidence of a "separate sheet" requirement. The employer did not present evidence of a reasonable and legitimate business reason for terminating the applicant.

The WCJ ruled the employer had violated Labor Code §132(a). The employer filed a Petition for Reconsideration. The appeals board agreed with the WCJ, concluding that Labor Code §132(a) had been violated, given applicant's credibility that he had been singled out for termination because of his injury, and that the employer failed to present evidence of a legitimate basis for applicant's termination.

The appeals board observed that state policy requires there should not be discrimination against workers who were injured industrially and that Labor Code §132(a) protects employees who exercise workers' compensation rights from retaliation or discrimination.

The appeals board citing *Department of Rehab. v. WCAB (Lauher)* (68 CCC 831), stated that "Labor Code §132(a) is interpreted liberally to achieve the goal of preventing discrimination against workers injured on the job while not compelling the employer to ignore realities of reemploying workers who were no longer able to perform the same job duties."

The appeals board citing *Smith* (49 CCC 212) and *Barns* (54 CCC 433) stated those cases hold that an employer's action that cause detriment to the employee because of an industrial injury was sufficient to show violation of Labor Code §132(a). *Lauher* deemed the *Smith* and *Barns* analysis to be correct but analytically incomplete, and stated that the claimant must show that he or she had a legal right to receive or retain the deprived benefit or status, and the employer had a corresponding legal duty to provide a refrain from taking away that benefit or status.

Under *Lauher*, for an employee on the same legal footing as other employees, a prima facie case for discrimination can only be established if the employee has been singled out for disadvantageous treatment. The appeals board held that under *Lauher* the applicant must show: (1) that he or she suffered an industrial injury, (2) that he or she also suffered some adverse consequence resulting from an action or inaction by the employer triggered by the industrial injury, (3) a legal right to receive the deprived benefit or status, and (4) the employer's corresponding legal duty to provide or refrain from taking away that benefit or status.

The fact that applicant was singled out by the manager at the meeting and told he should seek another job because he was always hurt, and later suspended and shortly thereafter terminated, along with the WCJ finding that the testimony was credible, the WCAB found the evidence supported a violation of LC 132(a).

The panel found no merit in the employer's contention that applicant failed to establish a prima facie case of discrimination. Further, the employer failed to present any witness testimony demonstrating the existence of a policy requiring employees to sign in and out of work on a separate sheet of paper. Nor could the employer justify the termination of a worker who had complied with the requirements in its employee manual to record worktime by punching a timecard in and out of work.

The WCAB agreed with the WCJ and the opinions expressed in his report.

22. Clerical mistake

Mendoza v. Vintage Senior Living (BPD) 2019 Cal. Wrk. Comp. P.D. LEXIS 19

The WCJ issued an Order Approving Compromise and Release. The Compromise and Release Agreement provided there was a good faith dispute as to AOE/COE and if that issue was resolved against the applicant, it would eliminate his right to recover benefits. The settlement included resolution of the supplemental job displacement voucher. However, the WCJ did not make an express finding of the good-faith dispute in the Order Approving Compromise and Release. The WCJ then issued upon request a nunc pro tunc order amending the Order Approving Compromise and Release to comply with *Beltran v. Structural Steel Fabricators* (81 C.C.C. 1224).

When the applicant sought the supplemental job displacement benefit a month after the settlement, the WCJ issued the amended order finding a good faith dispute existed that, if resolved against the applicant would defeat her right to recover benefits.

The WCAB explained the WCJ could use the nunc pro tunc procedure to correct the record to reflect what was previously decided but incorrectly recorded.

The WCAB concluded the WCJ intended to include the issue of supplemental job displacement benefit voucher and properly used the nunc pro tunc order to correct the record on an agreement that was previously decided but incorrectly recorded.

23. MTUS

Ibarra v. Ashley Furniture Industries (BPD) 2018 Cal. Wrk. Comp. P.D. LEXIS 618

The WCAB denied lien claimant's payment for compound medications because the treatments were not in compliance with the MTUS. The WCAB ruled they had jurisdiction to determine whether the treatment was reasonable and necessary because the defendant did not conduct utilization review. However, the appeals board found that the lien claimant did not provide substantial medical evidence that the medication it provided was reasonable and necessary under the MTUS guidelines.

The appeals board found that the MTUS guidelines in effect at the time the services were provided where not silent on the issue of compound topical analgesics. The appeals board ruled, pursuant to the MTUS, the treatment provided by the lien claimant was not recommended.

24. Apportionment

Mills v. American Medical Response (BPD) 84 C.C.C. 555

The WCJ found the applicant sustained an industrial injury resulting in permanent total disability without apportionment and a need for further medical treatment. The judge found the disability was caused by four separate specific injuries and one cumulative trauma injury, but issued an unapportioned award between the industrial injuries.

The facts established that the orthopedic Agreed Medical Evaluator (AME) was able to apportion between the industrial injuries and the internal medicine AME was not able to apportion the internal disabilities between the separate dates of injury. This case involves six AMEs, five of which apportioned and one could not. In addition, the orthopedic AME found that all of applicant's total disability was caused by his medical treatment, a disastrous result from a spinal stimulator replacement and removal.

Defendant Filed a Petition for Reconsideration contending the WCJ erred in finding there was no legal basis to apportionment between applicant's separate industrial injuries where only one of the six AMEs was unable to apportion between the four dates of injury. Defendant argues that while it agrees the applicant is permanently totally disabled, the permanent disability arising from each successive injury must be separately rated.

The WCAB affirmed the judge's decision.

Defendant argued that the fact that the AME in internal medicine was unable to apportion applicant's internal disability between the separate injuries, should not negate the apportionment determination. Defendant argued that a single physician's determination that he is unable to parcel out the approximate percentage to which each distinct industrial injury causally contributed to the employee's overall permanent disability should not preclude reliance upon another physicians apportionment determination.

In *Benson* (72 C.C.C. 1620), the appeals board held that where multiple industrial injuries combine to cause permanent disability, the permanent disability caused by each injury must be separately calculated unless the evaluating physician cannot parcel out, within reasonable medical probability the approximate percentage of overall disability caused by each industrial injury. The appeals board further held that if a physician opines that the approximate percentage of disability caused by each injury cannot be reasonably parcel out, then this constitutes an apportionment determination within the meaning of Labor Code §4663.

Defendant argues that a single determination that he is unable to parcel out the approximate percentage to which each distinct industrial injury causally contributed to the employees overall permanent disability should not preclude reliance upon another physician's apportionment determination.

The appeals board cited the case of *Dileva*, writ denied, in which the applicant sustained a cumulative orthopedic, psychiatric and gastrointestinal injury and two specific orthopedic injuries. The WCJ found applicant's orthopedic and psychiatric permanent disability were

inextricably intertwined, where the psychiatric evaluator was unable to parcel out the psychiatric disability between the dates of injury, despite the fact the orthopedic AME was able to apportion the orthopedic disabilities between the separate dates of injury. In affirming the WCJ, the appeals board rejected the defendant's contention that under these circumstances the WCJ should have apportioned the psychiatric disability in accord with the orthopedic apportionment.

In the case of *Fields*, 78 C.C.C. 896, an orthopedic AME was able to make an apportionment determination between the permanent disability caused by a specific and a cumulative trauma injury, the internal AME concluded he was medically unable to parcel out the percentages to which each separate industrial injury causally contributed to applicant's overall permanent disability. The appeals board panel followed the internal AME's opinion that the disability caused by the specific and the continuous trauma was so inextricably intertwined it could not be separately rated. The panel held that where the internal medicine AME provided a valid medical opinion, he met the requirements of §4663, that a physician make an apportionment determination.

The appeals board also cited the case of *Herrera* (84 C.C.C. 17), where the appeals board awarded a single joint award of permanent disability for a cumulative trauma where an orthopedic AME provided an apportionment determination pursuant to *Benson* between a continuous trauma and specific injuries, but the AMEs in internal medicine and psychiatry were unable to parcel out disability between the separate injuries. The panel held that the orthopedic apportionment determination could not be applied to the disability caused by the other parts and symptoms.

The WCAB indicated the panel decisions support the WCJ's decision in this case. In addition, applicant asserted there cannot be apportionment of permanent disability where applicant's permanent total disability was directly caused by the medical treatment he received for the industrial injuries pursuant to the case of *Hikida* (82 C.C.C. 769)

In that case, it was held that applicant was entitled to an unapportioned award of permanent disability, when the apportionment arises directly from unsuccessful medical treatment, even though the need for the surgery or medical treatment was necessitated by both industrial and nonindustrial factors.

The court in that case held that permanent total disability was caused not by carpal tunnel syndrome but by the CRPS that was caused by the medical treatment the employer provided resulted in an apportioned award. The issue is whether an employer is responsible for both the medical treatment and disability arising directly from unsuccessful medical intervention without apportionment. The court concluded the employer was responsible for both the medical treatment and the permanent disability in such a situation. The important caveat was the resulting permanent disability had to rise directly from the unsuccessful medical treatment.

In this case the AME testified that applicant was 100% permanently disabled as a result of the complications from the implant and removal of the spinal cord stimulator, which could not be apportioned between the specific and the cumulative trauma.

The appeals board held that applicant's permanent total disability arises directly from the effects of the surgery to treat his industrial injuries and cannot be apportioned between them or to any other source.

The Petition for Reconsideration was denied.

25. Permanent Disability

Bagobri v. AC Transit (BPD) 85 C.C.C. 61

This matter was heard on the sole issue of applicant's level of permanent disability. After trial, the judge determined that applicant was 100% disabled, specifically rejecting to follow the holding in *Dept. of Corrections & Rehabilitation v. W.C.A.B. (Fitzpatrick)* (2018) 83 Cal. Comp. Cases 1680. The judge further rejected the apportionment found by the agreed medical examiner.

WCAB affirmed the WCJ's finding that applicant, a bus driver, sustained 100 percent permanent disability "in accordance with the fact" under Labor Code §§4660 and 4662(b), without basis for apportionment, as a result of the 3/24/2005 admitted industrial injuries to his lumbar spine, nose and psyche, due to an altercation, when the orthopedic agreed medical examiner and applicant's vocational expert opined that applicant was unable to sustain gainful employment and had total loss of future earning capacity due to his industrial injuries. The WCAB disagreed with defendant's assertion that the holding in *Fitzpatrick*, precluded finding of permanent total disability "in accordance with the fact" based on applicant's work restrictions, and limited permanent total disability findings to whole person impairment ratings calculated pursuant to permanent disability rating schedule. The WCAB reasoned that because the 2005 Permanent Disability Rating Schedule (PDRS), which was issued pursuant to Labor Code §4660, expressly defines permanent total disability as disability causing total loss of earning capacity, and that because the award of permanent disability based on the injured worker's inability to work/loss of earning capacity is consistent with Labor Code §4660 and PDRS, the holding in *Fitzpatrick*, cannot be interpreted to preclude an award of permanent total disability in cases of inability to work and must be limited to specific facts in that case. The judge reasoned that interpreting *Fitzpatrick* to preclude an award of permanent total disability where applicant is unable to work is further unjustified as such interpretation conflicts with all other published case law addressing the issue, including the decision in *Ogilvie v. W.C.A.B.* (2011) 76 Cal. Comp. Cases 624, that where applicant has lost all future earning capacity (and absent apportionment), WCAB must issue an award of permanent total disability under Labor Code §4662(b), even though the award, is issued pursuant to PDRS and Labor Code §4660. The judge determined that a finding of permanent total disability "in accordance with the fact" can be based on medical evidence, vocational evidence or both, and that in this case there was substantial medical and vocational evidence to support a finding of 100 percent permanent disability based on applicant's work restrictions and preclusion from gainful employment.

The WCAB denied reconsideration, adopting and incorporating the WCJ's report and recommendation.

26. Jurisdiction

Gault v. Workers' Compensation Appeals Board (BPD) 84 C.C.C. 112

Applicant sustained an admitted injury on 4/14/14 to his right knee while working as a groundskeeper. Applicant had prior knee injuries to the same body part which included a knee replacement. As a result of the industrial injury applicant needed additional surgery to the knee. Applicant developed an infection on the knee which required multiple procedures to drain. His condition did not improve and he was ultimately placed on chronic antibiotic treatment. Applicant was evaluated by Dr. Bellinger, QME in internal medicine. and Dr. Tapper, QME in orthopedics. Dr. Tapper, after apportionment, found a 3% disability. Dr. Bellinger during deposition noted that applicant's future medical treatment required long term monitoring of his long term antibiotic therapy. "Applicant will require lifelong antibiotic therapy, which by its nature, will lead to multiple long term medical problems." The doctor testified to multiple long term problems the applicant will likely experience due to the therapy. However, currently applicant was not suffering from any of the effects that he cited as likely to arise from the antibiotic therapy. The applicant will have future complications per QME Bellinger. The WCJ found applicant sustained a 31% disability based on the 3% impairment from Tapper and the 20 WPI from Bellinger. Defendant filed for reconsideration.

On recon, the WCAB found that the case falls within the category of insidious progressive diseases that permit an interim award of permanent disability with a reservation of jurisdiction beyond the limitation period, which establishes a five-year limitation from the date of injury for awards of disability benefits. They cite *General Foundry Services v. WCAB* (Jackson) 51 C.C.C. 375, which found that for such diseases which have a long latency period and may not become permanent and stationary within five years, the board may reserve jurisdiction beyond the five year period. They state that it has been repeatedly recognized since Jackson that a reservation of jurisdiction applied only to cases involving such an insidious progressive disease. They determined that applicant is entitled to a finding that he will suffer additional permanent disability in the future for which a reservation of jurisdiction is justified. The WCAB granted recon and amended the award to provide for an interim award of 3% based on the Tapper report after apportionment with jurisdiction reserved to award an increase in permanent disability pursuant to the findings of Dr. Bellinger.

27. Dependency

Haney v. County of Kern (BPD) 2019 Cal. Wrk. Comp. P.D. LEXIS 101

Labor Code §3501(b) provides that a spouse to whom a deceased employee is married at the time of death shall be conclusively presumed to be wholly dependent for support upon the deceased employee if the surviving spouse earned thirty thousand dollars ($30,000) or less in the twelve months immediately preceding the death. In this case the employee's widow actively earned less than $30,000 in the 12 months preceding the employee's death.

The employee was injured in 2008 and spent two years prior to his death in 2012 primarily in the hospital. Because the employee had no earnings in the 12 months preceding his death, the employer argued the employee was dependent on the spouse at the time of his death, not vice versa.

The WCAB held that because the spouse met the requirements of Labor Code 3501(b), the conclusive presumption applied, and it did not matter that the employee did not work since 2008.

The WCAB also held that the spouse's passive income from pensions, annuities and taxable Social Security benefits did not count toward her earnings, and she was entitled to a conclusive presumption of total dependency.