Senate Bill 899:
Two Years Later

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INTRODUCTION

It has been a little over two years now since the passage of Senate Bill 899, the most dramatic change to the California Workers' Compensation system in the history of the State. We had completed a summary of the Bill immediately after it was promulgated. This was entitled "SB 899: A First Look". Now we are publishing an updated version of this summary.

Quite a bit has happened in the last two years. We had a new Administrative Director, Andrea Hoch, who was confirmed and later moved on. (She has been replaced since then by acting Administrative Director Carrie Nevans.) During her tenure and through the present date, Regulations were promulgated – usually after several versions were proposed – that helped shape our understanding of this radical reform. These were often the subject of vigorous debate. Also, multiple court decisions have been handed down that have provided guidance, and sometimes additional confusion. Beyond all this, the culture of the newly formed law has begun to be defined. We have a taste now for how all this will work in practice. Most battles have not yet been fought to a conclusion, but at least we have some idea of what the issues are.

A more developed analysis of SB 899 is now possible. This updated version of our original booklet is intended to be both a reporting on the changes over the last year, and a more in depth exploration of some of the issues. Much of the original booklet is still here. There is also a tremendous amount of supplementary reporting and analysis. While it is impossible to prepare a comprehensive look at all that has transpired over the last two years, and to encapsulate all possible issues currently available to parties, this booklet is nevertheless intended as a comprehensive look at the present state of how SB 899 has evolved.

However, it remains important to realize that we are still very much in the infancy of understanding this new law. It will indeed be years and perhaps decades before the final battles are fought and full understanding is achieved. For now, we need to stay abreast of developments as they occur. Some of us may be lucky enough to help shape the debate.

I am a defense attorney and what follows is written from a defense perspective. Advice is given where appropriate as to what positions the defense should take. The positions and tactics of applicant's attorneys are anticipated where reasonably possible. This booklet is intended to be used as a frequent reference, by defense attorneys and claims adjusters. It is written in a direct and sometimes informal manner in order to meet that goal. It is divided into identified sections for reference purposes.

A complete copy of this booklet and summaries of other major reforms may be found on our website, mikeslaw.com. You may of course contact us at any time. Our last publication resulted in dozens of training seminars and about two thousand copies distributed.

I would like to thank those that took the time to help me write this. These include my assistant and soon to be law student Megan Sullivan, who spent almost as much time on this as I did. I would also like to thank the other members of this firm who gave me their contributions, including all the attorneys and staff who discussed issues with me. Attorney Joel Allan and our office manager Yvonne Bar-Yotam read through this in detail; Bart Sullivan stepped in to help me reason through more than one difficult area. I received extensive commentary on network issues from Patrick Williams at American Commercial Claims Administrators (ACCA); this man

knows more about networks than any human should. Also, Dave Chetcuti at ACCA saved me from making several embarrassing mistakes. I sought review from the members of the applicant's Bar, and I want to extend thanks to Adam Domchik, who went through this with me in detail. Adam demonstrates a comprehensive knowledge of the law. I also appreciated the input of Elliot Berkowitz, and Ron Feennberg. I received advice from Darrell Brown at Sedgwick.

Also, I have attended the CAAA conventions and the speakers there have been invaluable to me in giving the perspective and clever interpretations of my opposition. The commentaries and news provided on the website Workcompcentral were reviewed in their entirety, and often added tremendously to my viewpoints. Workcompcentral is an excellent source of information, as has become an essential part of any competent practice in this area. David DePaulo there reviewed this booklet for me.

Finally, the inevitable disclaimer. This booklet is a summary look at a very complex and difficult change to an already complex and difficult area of the law. The development of the interpretation of SB 899 is just beginning. No matter when the reader references this booklet, it will already be out of date. Opinions expressed here are just that, opinions, and are subject to change or revision as the workers' compensation community continues with the process of incorporating SB 899. Therefore, the commentary here should not be utilized as legal advice for any given case or situation without consultation with a licensed attorney.

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PROLOGUE: THE EFFECTS OF SB 899

The obvious goal of SB 899 was to decrease the cost of worker compensation in California, and it has certainly done that. Before SB 899, there were significant reforms in 2002 and 2003. It is not completely easy to discern which of the reforms contributed in which proportion to the results reported on thus far.

The Workers' Compensation Insurance Rating Bureau (WCIRB) released a report at the end of 2005, reporting that the three reforms have erased a $12.9 billion dollar deficit in reserves, creating a five billion dollar surplus in its stead. California written premium in 2005 was down 11% from the prior year, and the average statewide insurer rate was down 15% in the second half of 2005, and 30% below rates charged for the second half of 2003. Claim frequency in 2005 dropped 18% from 2004. At this writing, the latest in a series of pure premium rate decreases from the WCIRB has been proposed in the amount of 16.4%. This if approved will bring the total rate reductions following the 2003 and 2004 reforms to 58%.

Labor Code § 138.65 was added as part of SB 899. This directed the Administrative Director to contract with a qualified organization to study the effects of the 2003 and 2004 Legislative reforms on workers' compensation. On January 1, 2006, Bickmore Risk Services (BRS) published the study. It was reported that reforms since 2003 had saved fifteen billion dollars. Average pure premium rates dropped from $4.81 per $100 of payroll to $2.59, and total charged rates showed a similar decline. California, according to this study, is no longer the most expensive state in which to do business. Multiple carriers are either entering California or competing for a greater market share. State Fund had reduced its share from 58% of the market in 2003 to 41% in 2005. In 2005, the average rates charged by other carriers were 15.2% less than State Fund's, so this trend is likely to continue.

One of the most interesting aspects of the report was the breakdown given of the origin of the savings. 40% comes from permanent disability, 27% from treatment guidelines, 13% from reduction in medical fees and 12% from cuts to vocational rehabilitation. Some had expected that utilization review and the end of vocational rehabilitation would comprise a greater percentage of the savings. These results are supportive of the argument that SB 899 is having an impact. We can expect more to come, as aspects of SB 899 such as the networks and the new permanent disability schedule are just beginning to get traction.

Labor Code § 138.5 concluded that if the savings were not found to be passed on to the employers, the governor and Insurance Commissioner would be allowed to submit proposals to the Legislature regarding state imposed rate controls. This has been an agitation on the part of applicants and applicant attorneys since the passage of SB 899, which to this point has not been realized. They complain that carriers are keeping too much of the profits. One survey performed by the Union Bank of California in March 2006 had small businesses complaining that more of them had seen a rate increase than a decrease. Carrier representatives are cautious about returning to unrealistically reduced rates. Nobody wants a repeat of what happened in the

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nineties, when underselling lead to the collapse of the system. Of course, applicants and their attorneys are visibly upset about a reduction in benefits as well.

There have been other studies of significance. The Commission on Health and Safety and Workers Compensation (CHSWC) performed a study of the reduction in permanent disability and found a 54% reduction between the old and the new permanent disability schedules. In February of this year, it was recommended that the permanent disability rating schedule should be adjusted by July 1 to rectify this. However, the acting Administrative Director has refused to consider this without further data on the effects of the schedule as it stands, and has suggested that changes, if made, will not be put into place before 2007. As described further herein, this is a key concern.

It seems inevitable that some further reform, probably in the form of some rollback of SB 899, is inevitable. How long this will take, and what form it will take, is a matter of continuing and intense interest.

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COMMENCEMENT DATES FOR NEW PROVISIONS: A QUICK REFERENCE

SB 899 is an urgency statute. That is, it passed in the legislature with the requisite number of votes to have its provisions take effect without any delay. Included within it is § 47 of the Act, which says that ". . . any provision of law made by this act shall apply prospectively from the date of enactment of this act regardless of the date of injury, unless otherwise specified...". So, for the most part, the provisions of SB 899 applied immediately, and for all cases.

The legislature was careful to try and protect closed files though. The same Section specifies that the changes cannot be used to set aside any Findings and Order, or a settlement by way of Stipulation. It is stated specifically that any "existing order, decision, or award" may not be disturbed.

There were substantial debates as what these provisions meant, although these debates are just about settled now. Most of the argument over this language took place in the context of cases concerning apportionment, and these are described in detail herein. The rule seems to be this. Unless there is a final order and award, and all the appeals have been exhausted, the change in the law is in effect, regardless of the date of injury.

There are some areas where the statutes themselves specified that the change in the law would only take place for certain dates of injury. Thus, despite understanding of the general rule, there remains a variance. What follows is a chart for quick reference on the subject of when a given change in the law takes effect. A question mark indicates that there is still substantial debate over the point, and page number is referenced that describes the situation.

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ISSUE	APPLICATION
Definition of medical treatment to include ACOEM.	As of 04/19/04, retroactively, for all dates of injury.
New rules on Pre-Designation.	As of 04/19/04, retroactively, for all dated of injury; unless injury has occurred and treatment relationship is established.
Demand for prior authorization of treatment.	As of 04/19/04, retroactively, for all dates of injury.
End of treating doctor's presumption.	As of 04/19/04, retroactively, for all dates of injury.
Immediate Medical Care.	As of 04/19/04, retroactively, for all dates of injury.
Network & Network Modification.	As of 01/01/5, retroactive, for all dates of injury, with delays in some cases.
New Med-Legal Process: Unrepresented Employee.	Cases with date of injury on or after 04/19/04, where med-legal procedures have not been eliminated.
New Med-Legal Process: Represented Employee.	Cases with date of injury on or after 01/01/05.
Temporary Disability Limitation.	Dates of injury on or after 04/19/04.
Application of New PD Schedule.	As of 04/19/04, retroactively, for all dates of injury with 3 exceptions. **?**
Raised PD Payments.	Dates of injury on or after 01/01/05.
Continuity of Payments.	As of 04/19/04, retroactively, for all dates of injury.
Return to Work Rules and PD Adjustment	Dates of injury on or after 01/01/05. **?**
Apportionment	As of 04/19/04, retroactively, for all dates of injury.
Penalties (New LC § 5814)	As of 06/01/04, retroactively, for all dates of injury.
Reform of Legal Standard	As of 04/19/04, retroactively, for all dates of injury.
Clean-Up Legislation	As of 04/19/04, retroactively, for all dates of injury.

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1. Medical Treatment Redefined

There are many changes made in Labor Code § 4600, which is of course the foundational Code for the provision of medical care.

A. Definition of Medical Treatment

Labor Code § 4600 has provided a relatively broad definition of medical treatment, which has set the tone for workers' compensation treatment for decades. Specifically, treatment is mandated "that is reasonably required to cure or relieve the injured worker from the effects of his or her injury." Subsection (a) of Labor Code § 4600 specifies that this treatment must be provided in a "reasonable" fashion. The formerly used word was "seasonable."

Added is Labor Code § 4600(b). It provides that notwithstanding any other provision of the law, medical treatment that is reasonably required to cure or relieve the injured worker means treatment that is based upon the Utilization Guidelines as adopted by the Administrative Director, or prior to the Administrative Director's action, per the terms set out in ACOEM. This is a definition of reasonable care that is a radical departure from the previous understandings of the same in the system. Furthermore, it is a "clean-up" measure, which strengthens the Utilization Guidelines that were originally enacted in the 2003 legislation.

B. Establishment of the Network

Labor Code § 4600(c) is also radically altered to help with the establishment of a treatment network as described later herein. This section had provided that after 30 days from the date of injury, the applicant could chose his or her own physician at a facility of his or her own choice within a reasonable geographic area. This is now limited to those circumstances where an employer network is not properly created.

C. Pre-Designation of Physicians

Labor Code §§ 4600 and 4601 had before SB 899 laid out a provision wherein the applicant could pre-designate a physician with the employer prior to the injury, and provided that the applicant could choose to be treated by that pre-designated physician regardless of employer control rules. This is a way out of the network.

SB 899 eliminated prior pre-designation language from Labor Code § 4600, and replaced it with § 4600(d), which allows for treatment by a pre-designated physician only under limited circumstances. Furthermore, the legislature left in place Labor Code § 4601, which contains provisions for a pre-designated chiropractor or acupuncturist in some circumstances. Only

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recently, Regulations have been adopted effective March 14, 2006. These are California Code of Regulations (CCR) §§ 9780 through 9784.

Regulation § 9780.1 confirms that a proper pre-designation will allow the applicant to treat with his own chosen physician, even if a network has been established. It goes further and states that even where a network is in place, "any referral to another physician for other treatment need not be within the Medical Provider Network." It seems that once medical control is lost by the defense, it is supposed to stay lost. Regulation § 1980.1 articulates that if the pre-designation paperwork is not available, then the matter is to proceed as if there was no pre-designation, but if it is later received and is found to be valid, the pre-designated physician may take over care.

Pre-Designation under Labor Code § 4600(d)

Under Labor Code § 4600(d), pre-designation is allowed when the applicant has notified the employer in writing prior to the date of injury that the applicant has a personal physician. Also, to put it simply, an employer has to have non-industrial health insurance for the applicant and the applicant be allowed to pre-designate and use a personal physician. Regulations §§ 9780 and 9780.1 have been created to supplement the statute. The latter provides that the employee does not have to participate in the coverage for this requirement to be met.

There are limits on what can constitute a "personal physician". The personal physician has to meet all of the following conditions:

1. The physician must be the applicant's regular "physician and surgeon", and must be licensed. This is a term of art found in the Business and Professions Code, and does not include chiropractors or acupuncturists. Thus, this provision excludes pre-designation of chiropractors and acupuncturists. As described herein, these may still treat patients in the network.

2. The physician has to be the applicant's primary care physician. This means that he or she has previously directed the medical treatment of the applicant and retains the applicant's medical records, including his or her medical history.

3. The physician agrees to be pre-designated. This could create a significant procedural barrier. The timing of this agreement is not specified.

As the changes brought about by SB 899 were brought to bear immediately, it does seem allowable - and advisable - to implement the new standards without delay. If an injury has already occurred, and the pre-designated doctor is already treating an employee, it is unlikely that the pre-designation changes will disturb that relationship. However, absent that sort of circumstance, the changes take effect for all dates of injury.

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After this provision was passed, many employers decided to create pre-designation forms, which were distributed to the employees, along with notice that there was a new standard for pre-designation. This decision has been validated by Regulation § 9780.1, which requires qualifying employers to give their employees notice, with an optional form. It is not clear that this notice and form are a precondition to the mandate of the new pre-designation statutes. It is clear that if the conditions of pre-designation are met then it takes effect regardless of whether this form is used.

Before these Regulations were published, employers sometimes created forms that asked for more than just the signature of the physician. They often asked for confirmation of the proper licensing, and that he or she had previously directed the medical treatment of the applicant and retained the applicant's medical records, including his or her medical history. All of these are requirements for a physician to be properly pre-designated. However, the new Regulations made it clear that this sort of inquiry is not allowed. The employer is specifically prohibited from ". . . contact(ing) the pre-designated personal physician to confirm pre-designated status or contact the personal physician regarding the employee's medical information or medical history prior to the personal physician's commencement of treatment for an industrial injury."

Regulation § 9780.1 does require that the applicant's physician must consent to the role. The physician does not have to sign the optional form provided. However there must be written evidence of consent before the injury in writing for the pre-designation to be valid.

Regulation § 9780.2 has been repealed. Its provision that the employer provide emergency and first aid medical care has been reenacted under Regulation § 1980.1. Regulation § 9780.1 also lays out a series of obligations for the claims adjuster where there is a pre-designation, including authorization of reasonable care, the furnishing of billing information, delivery of medical documents, and like requirements.

The Legislature is careful to avoid any disputes over medical treatment that will involve qualified medical evaluations and Court intervention. Labor Code § 4600(d)(3) specifies that if the employer does have non-occupational health care, those provisions of health care law which put into place a system for resolution of medical disputes are dispositive of any such disputes. This is similar to the structure described herein, where treatment disputes arise within a network.

Labor Code § 4600(d) is given a sunset provision. That is, unless this system is re-ratified by the Legislature and passed by April 30, 2007, it will no longer exist. That will eliminate pre-designation except under Labor Code § 4601.

Pre-Designation under Labor Code § 4601

This section of the Labor Code was left alone by SB 899, whether intentionally or not. It must be reckoned with as it lays out a separate set of circumstances under which pre-designation may be allowed. Regulation § 9781 was recently confirmed to supplement this statute.

Section 4601(a) specifies that the applicant is entitled to request a change of treating physician. It is not specified that this be in writing. The defense has five days to provide ". . . an alternate physician or, if requested by the employee, a chiropractor, or an acupuncturist. . ." This section precedes Labor Code §§ 4601(b) and 4601(c) which speak to the right of the employee to pre-designate an acupuncturist or chiropractor under some circumstances. However, § 4601(a) arguably stands on its own. Accordingly, it has significance beyond the question of pre-designation. As discussed herein on topic of networks, it does appear that the applicant retains the right to change treating physicians and request care from a chiropractor or acupuncturist.

In regards to pre-designation, § 4601(b) and 4601(c) specify that the applicant who is requesting a change of treating physicians is allowed to be treated by a chosen chiropractor or acupuncturist (respectively) where that chiropractor or acupuncturist was pre-designated. The chiropractor or acupuncturist becomes the applicant's "personal chiropractor" or "personal acupuncturist" under the Labor Code. The Regulations make it clear that this is only allowed in the context of a change of treating physician. Therefore the applicant cannot pre-designate a chiropractor or acupuncturist as a primary treating physician ahead of time. That sort of pre-designation is limited to a "physician and surgeon" as described above and as recited in new Regulation § 9780. Once the treating relationship is established however, the applicant may change to a chiropractor or an acupuncturist of choice where the pre-designation was properly done.

The Regulation makes it clear that it only applies to cases where no network is put into place. The implication is that where there is a network, this sort of pre-designation is not allowed. That may be a point of contention going forward. In those cases the employer only has thirty days of medical control, so the application of pre-designation under Labor Code § 4601 seems very limited. It is made clear that when there is no network, the employer is to provide a form to the employee advising of this right. Again a series of obligations is placed on the claims adjuster where there is proper pre-designation. Note that in this situation, there is no requirement that the chiropractor or acupuncturist hold records or previously have treated the applicant.

Pre-Designation Issues

Of course, the applicants will try to pre-designate physicians. We have not seen a mass pre-designation in too many places since the passage of SB 899, however, a proper pre-designation will definitely keep the applicant out of the network. What if the applicant pre-designates a physician and later transfers care? The only case available on this issue is *Withers v. The May Department Store* (2002) 30 CWCR 15. It was held in that case that the change of

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treating physicians did not revert treatment to the employer's control. However, this was a pre-SB 899, case so it is an open issue.

Other notice issues may be raised. It is clear for example that the applicant must be notified of his or her right to pre-designate a physician. This is laid out in Labor Code § 3550, and Regulations §§ 9780.1 and 9781. The 2002 reform legislation stated specifically that this notification is to take place at the time of hiring or at the end of the first pay period. This was established by Labor Code § 3551(b). In the case of *Albert Perez v. WCAB* (1999) 64 CCC 323 it was admitted that there was no posted notice of a right to pre-designate. The Court of Appeals indicated this was not enough of an infraction to cause the employer to lose medical control. This is excellent precedent for the defense in the present situation.

Labor Code § 4600(d)(5) indicates that no more than seven percent (7%) of all employees who are covered under the paragraph are allowed to pre-designate physicians at any given time. Obviously, all this is in place, at least in part, to ensure that there is no illusory pre-designation of a physician in order to circumvent the purposes of employer's establishment of a physician network and resulting control of medical care. How exactly this is to be determined or enforced remains a mystery.

D. Demand for Prior Authorization

Labor Code § 4600(d)(5) indicates that the insured may require prior authorization of any non-emergency treatment or diagnostic service, and may conduct a necessary utilization review pursuant to § 4610.

This has a huge potential. The defense may, under the language here, decide to demand pre-authorization for all non-emergency care and diagnostics. A failure to obtain such pre-authorization could be a basis for avoiding liability. The defense should make sure that the requirement of pre-authorization is clear if this approach is taken. It should be noted that this requirement takes place within the context of the pre-designation statute, and therefore may be limited to those cases.

E. The End of the Treating Doctor's Presumption

Over the last few sessions, the Legislature has tried to scale back and limit the treating doctor's presumption. Now it is finally eliminated, even in cases of a pre-designated physician. Simply stated, Labor Code § 4062.9 is repealed. This has the effect of eliminating the presumption altogether.

In the *en banc* decision of *Terry Martinez v. California Building Systems* (2005) 70 CCC 202, the WCAB held consistent with its other opinions that the presumption was eliminated for all dates of injury. This was true unless the decision of the WCJ had become final before April 19, 2004, where "final" meant all appellate rights have been exhausted. *Martinez* was consistent

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with previous writ denied cases preceding it, including *Garnett (Johnson) v. WCAB* (2004) 69 CCC 1467, *Ramon Garcia v. WCAB* (2005) 70 CCC 60, and *Gonzales v. WCAB* (2004) 69 CCC 1472. Thus, it appears that as of April 19, 2004, if you have not got an award from the judge based on a presumption, and exhausted the appeals options, this issue will not serve you.

F. The Fee Schedule Addressed

Labor Code § 4603.2 is amended. Subsection (b) formerly provided that the defense had to make payment for medical treatment within 45 days after receipt of each separate billing. Language has been added here to indicate that such payment is to be made "at the reasonable maximum amount in the official medical fee schedule, pursuant to § 5307.1 in effect on the date of service." This mandates payment according to fee schedule without qualification. It also "cleans up" the 2003 reform bill language, which did not specify what dates of injury or dates of service would apply for implementation of new fee schedule rules.

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2. Immediate Medical Care

Section 5402 of the Labor Code is well known by all parties in the system. That section provides that a claim must be accepted or denied in ninety days.

This section has been amended to indicate that an employer must provide medical treatment to the applicant in the period before any denial issues. Specifically, the new Labor Code § 5402(c) specifies that within one working day after the employee files a claim form, the employer must authorize the provision of all treatment consistent with the utilization guidelines. This treatment is to continue until the date that liability for the claim is accepted or rejected. This takes effect for those cases where the claim form is received from the employee on or after April 19, 2004.

The incredibly important case of *Honeywell v. WCAB (Wagner)* (2005) 70 CCC 97 was handed down by the Supreme Court after SB 899. It spoke to the issue of timely denial under § 5402(b). The ninety days to deny a case according to *Honeywell* begins to run, absent egregious behavior on the part of the employer, only when the completed claim form is received back from the employee, and not upon notice of industrial injury alone. At that point it is considered "filed". As discussed in the section on medical treatment herein, treatment is due from the filing of a claim form, with some qualifications.

There is a $10,000 limit on the expense of this medical treatment up until the time of denial or acceptance of the claim. Furthermore, it is specified in Labor Code § 5402(d) that this treatment provided does not give rise to a presumption of liability.

This rule has caused some level of consternation. From the defense perspective, the applicant is now entitled to benefits even before it is established that a work related injury exists. It is not inconceivable that a person explicitly manufacturing a false claim could receive extensive medical benefits under this new rule. In fact this has probably already happened more than once. It has been pointed out that Labor Code § 3602(c) states explicitly that if industrial injury did not occur, "the liability of the employer shall be the same as if this Division had not been enacted." There is a contradiction here.

There is no reason to think that this requires the provision of unwarranted care, nor does it require care in excess of mandated standards, (i.e., the ACOEM guidelines). Nevertheless, it has been held by at least one local Judge (in the case of *Heike Ruvalcaba v. Scott Roberg,WCAB No.* (OXN 0129714)), that a lien claim for treatment done before a denial issues is compensable, even if the lien claim is filed after the denial date. The lien claimant would be wise to submit the bill quickly in cases where there is a prospective denial and it looks as though the $10,000 will be used up rather quickly. The adjuster should keep track of payouts before the denial.

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The defense is well advised these days to deny a case quickly if possible. Accordingly, we are seeing many adjusters become circumspect about how much evidence is required to sustain a denial that will hold up under the scrutiny of an audit. Gone are the days of full-blown discovery, complete with a deposition, one or more QMEs, subpoenaed records, etc., performed on every case before a denial issues. Only a "factual, legal, or medical basis" per Regulation § 10111 and § 10111.1 is required. Accordingly, an indication from the insured that a case has no merit should be followed up quickly with an investigation sufficient to support a denial. The only question should be if there is a sufficient basis for denial. If further discovery warrants, the case can always be picked up later.

If medical evidence is required, the med-legal process should be delayed, if feasible, in favor of an opinion by the treating physician. With networks in place, the initial opinion of the treating physician in this situation can perhaps be obtained quickly, and without bias against the defense. Also, there is no statutory bar against communications with this physician. The medical legal process in its new form requires a panel QME or an AME, and often these evaluations cannot be obtained within the ninety days; even if they can, the defense can run through a lot of medical costs in a suspect case before the report comes in. The Labor Code reiterates in several places that the treating doctor's opinion is admissible as evidence.

Some have suggested obtaining a speedy evaluation under Labor Code § 4050. As further discussed in the section on medical-legal evaluations, there may be some question as to the defense's entitlement to obtain these evaluations, as Labor Code § 4060 prohibits any medical-legal evaluation to determine the question of compensability other than the procedures outlined in §§ 4062.1 and 4062.2. Almost certainly, these reports will not be admissible. If an applicant objects, the defense may not be allowed to force attendance.

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03. Employer Controlled Medical Treatment

Employer control of medical treatment was one of the most hotly contested and most dramatic changes of this reform legislation. In the past, the applicant's ability to control medical treatment thirty days after injury was a key problem for the defense, especially in combination with the treating doctor's presumption that existed for so long. An entire treatment industry developed, with well-known applicant's physicians consistently exaggerating the need for treatment, adding body parts, maximizing claims for permanent disability and – it cannot be denied – getting rich. The applicant's control had existed since 1976.

To a large and growing extent, all of that has changed. SB 899, in one of its most dramatic changes, set up the network system. To put it simply, as of January 1, 2005, if the defense has a network of physicians in place, it retains complete medical control throughout the lifetime of any claim for injury on any date. Combined with utilization review, this has changed the landscape of treating work related injuries in California.

It is Labor Code § 4600 that first references the discussion of an employer network. Labor Code § 4600 used to provide for the applicant's ability to select a physician of his or her own choice at a facility of his or her own choice, 30 days after the date the injury was reported. This is now conditioned on the factor of whether the "employer or the employer's insurer" has established a medical provider network (MPN), as provided for in Labor Code § 4616. Where such a network is established, the choice is limited to those physicians that exist inside the network.

It should also be noted that the legislature and the Administrative Director have been careful to protect the injured workers' access to quality of care. Various standards have been set on these points as described herein. It is provided that the employer may allow the applicant to treat outside the network when it so chooses. There is even one provision, Labor Code § 46163(d)(2) (backed up by Regulation § 9767.5) that allows for treatment by a specialist outside of the network "on a case by case basis" where one is not available within the network.

A. Establishing the Network System

Labor Code § 4616 indicates that on or after January 1, 2005, a MPN may be set up by an "insurer or employer." The statutory scheme encompasses Labor Code § 4616 through 4616.7. After SB 899 passed, there was a tremendous response to this opportunity. Various networks were created and marketed in a very expeditious fashion. At this writing, virtually every insurance carrier and self-insured entity has a network in place, and is continuously working to implement it. Eventually, it seems that almost all cases in the state will be treated within the network.

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The Administrative Director was asked to provide Regulations pertaining to networks, and after several drafts, we finally got a permanent set in September of 2005. The Regulations pertaining to networks are numbered §§ 9767.1 through 9767.15.

The Networks Established

Traditional HMOs and PPOs scrambled to have their organizations identified as a network. Independent networks have also been formed. In some cases the larger networks have turned out to be not much of a threat to applicant attorneys. It is not uncommon for some of the most infamous applicant-oriented physicians to be – at least initially - on a given network panel. Beyond that, many applicant attorneys have found that they are able to find doctors suitable to them on the panel list. These panels are being circumscribed a little at a time after their original formation.

It is certainly true that the network system is not having the extreme chilling effect on litigation that was anticipated at the start of this process. It is surprising to see that many physicians operate with a comfortable and unexpected level of autonomy – at least within the confines of utilization review. Employers by no means have the anticipated level of consistent defense orientation or the responsiveness to defense pressure that was so greatly feared before this process began.

Before the networks, applicant's attorneys sometimes had felt that they had little control over the perceived abuse of medical care in their caseloads. They often see more efficient care and quicker turnaround as a boon to their business of law. They have also found clever ways of avoiding the network, as described further below. All in all, networks have had and do have a growing positive effect for the defense. However, they have not broken the litigation system, nor have they met the initial expectations of the defense.

Network Standards

Why has a system, once so feared, been so diffused in practice? One answer is the stringent demands placed upon the defense when constructing a network. These demands have the effect of forcing the defense into allowing a huge numbers of providers into the network, thus limiting its control. The legislature in Labor Code §§ 4616 and 4616.1 had provided specific standards to make sure that the care provided by networks was adequate. Subsequently, Regulations were passed which accentuated these demands. These are CCR §§ 9767.2 through 9767.5.

The Administrative Director is required to approve all prospective MPNs. There is a required written application, which is quite lengthy and detailed. If it is not denied within sixty (60) days it is deemed approved. It requires a complete exposition of compliance with outlined standards.

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Here are the factors involved:

1) The Labor Code provides that the network is to include "physicians primarily engaged in the treatment of occupational injuries and physicians primarily engaged in the treatment of non-occupational injuries. The goal shall be at least 25% of physicians primarily engaged in the treatment of non-occupational injuries." The Administrative Director in Regulation § 9767.3 (e)(9) has obligated confirmation of this standard in any application submitted.

2) It is important that the network be able to provide whatever treatment is necessary. Labor Code § 4616(a) indicates that the number of physicians in the MPN shall be sufficient to enable treatment for injuries or conditions to be provided in a timely manner. Only licensed physicians and those competent to evaluate the specific clinical issues involved in the treatment services are allowed to practice. There is also to be an adequate number and types of physicians "to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged and the geographic area where the employees are employed." Regulation § 9767.5 sets forth access standards. It is required that specialists, emergency care, and occupational care be available within given distances from the applicant's work or residence. Appointments are to be available within three days of request, and specialist appointments are to be available within twenty days. Regulation § 9767.5(h) specifically allows an injured worker to see a specialist outside the network if that type of specialist is not available within the network.

3) Section 4616(a)(2) indicates that medical treatment for injuries is to be readily available for reasonable times to all employees. It also allows for the relaxation of standards in certain rural areas. Also required is a written policy for medical care when an employee resides or is authorized by the employer to work outside the coverage area.

4) The Administrative Director is not allowed to withhold approval based solely on the selection of providers. It is specified that the employer or insurer have the exclusive right to determine the members of the network. On the other hand, physician compensation may not be structured in order to achieve the goal of reducing, delaying or denying medical treatment or restricting access to medical treatment. Regulation § 9767.3 demands written confirmation of that.

5) Labor Code § 4616.1. talks about the use of "economic profiling." This is the process of evaluating a particular physician or provider medical group or individual practice association, based on whole or in part on the economic cost of utilization and services associated with the medical care provided. If such profiling is utilized, the Administrative Director must be provided with a copy of the filing, and it must be available for public view as well.

6) Health care organizations and health care service plans, and even group disability insurance policies are deemed approved provided certain conditions are met as determined by the

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Administrative Director. This may allow them to circumvent the approval process to some extent. The specifics of this are outlined by Labor Code § 4616.7.

Network Modification

Regulation § 9767.8 deals with the process of modifying an existing MPN. Where such a modification is required, the defense is to submit a written application to the Administrative Director. This is to be denied or accepted within sixty days and there are to be no changes until there is approval. A failure to respond is deemed an approval. There are also provisions for reconsideration and even appeal.

This process is only required for important or "material" changes. The Regulation gives specific examples of what this means. Most interesting is the requirement that approval be sought if there is either a change of 10% or more in the physicians on the MPN panel, or a 25% or more change in the employees covered. Obviously, with time, both of those things will occur in any MPN. There is no qualification as to these changes taking place within any confined period of time, which means that each MPN will have to seek approval of modification intermittently, and in perpetuity.

This pertains directly to the problem of undesired doctors being left on the panel. If there is a change of less than ten percent of these, no approval need be sought, at least not immediately. Depending on the contracts with the physicians themselves, this seems to give the defense some room to maneuver.

Regulation § 9767.13 allows the Administrative Director to deny approval of application for an MPN and provides that the reasons for disapproval are to be stated in writing. The Administrative Director is also empowered under Regulation § 9767.14 to suspend or revoke a MPN. In both of those instances, a request for re-evaluation can be made and an appeals process is provided.

Some MPNs were created under emergency regulations before the permanent regulations went into effect. Regulation § 9767.15 provides that in many instances there is no requirement that a MPN submit a notice of plan modification.

Practical Problems

In managing MPNs, issues have arisen as to providers that want into the network, and providers that do not want to be there anymore. It has been pointed out that in *Popvin v. Metropolitan Life Insurance Company* (2000) 22 Cal. 4th 160, the California Supreme Court had upheld the right of the provider to a fair notice and a hearing prior to removal from the list of preferred provider status. This did not involve a workers' compensation case, but was analogous.

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However, in the case of *Palm Medical Group v. State Compensation Insurance Fund*, Case # CGC 03-421984, it was recently held that a provider had no cause of action when they were not allowed on the panel. At one point A $1 million jury verdict was reversed.

A legally defensible fair hearing process and credentialing system is recommended. Since an MPN can be suspended or revoked if one of the providers is found not to be properly credentialed, it is important to keep tabs on the entire MPN as time goes on.

There have been a number of day to day problems that have been occurring as this incredibly complex and huge system is implemented. In many instances the panels of physicians are not well considered. Many MPNs were created by converting an existing PPO. This was convenient as the contracts were already in place, but also often resulted in panels that included physicians undesirable to the defense. Doctors may discover their membership in a panel with unhappy surprise – they may have no idea of how the system works or how to write reports. Sometimes doctors cannot schedule appointments in a timely fashion, are no longer located in the indicated geographical area designated, or are deceased. All of these sorts of things have happened.

Hopefully these sorts of problems will be cleared up as time goes on. In the meantime, applicant's attorneys would do well to document the situation and move for an expedited hearing if it is not addressed immediately. The defense would do well to have a mechanism in place for quick and efficient adjustment of the MPN panels in order to avoid being charged with outright misrepresentations regarding the available physicians on the MPN.

B. Implementing the Network

The establishment of a treating network enables the employer or insurer to control medical care for all dates of injury, whether before or after the establishment of the network. Therefore, following the timely establishment of such a network, those injuries in the process of treatment can be transferred into the network. There are few applicant attorneys left who still try to argue that treatment within the network is only required for dates of injury in 2005 or later.

Initial Provision of Treatment

When a network is in place, the employer simply provides treatment by referring the applicant to a doctor within the network. This is explained in Labor Code § 4616.3 and Regulation § 9767.6. It is the obligation of the defense to schedule the initial appointment with the network physician. All necessary care is to be provided as per Labor Code § 4600, which explains the variety of treatment possibilities available to cure and relieve injury.

In this scenario, the applicant is to be notified of his or her right to be treated by a physician within the network, and of the method of finding alternative physicians, "after the first

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visit with the MPN physician". There is more on notice requirements below, but note that there is no specific time limit for this required notice.

The law at this stage seems to provide that the obligation to provide medical care is triggered by the filing of a claim form (as discussed below). Regardless, it is not completely unheard of for an employer to ignore notice of injury or attempt to circumvent the claims process. Applicant attorneys will certainly argue that a failure to provide such care in a timely manner will result in a loss of medical control and the right of an applicant to treat outside the network.

The new Labor Code § 5402(c) specifies that within one working day after the employee files a claim form, the employer must authorize the provision of all treatment. Such a position is supported by the Regulation § 9767.6(b),which pertains to network issues. That provides for provision of medical care within one working day "after an employee files a claim form under Labor Code § 5401". On the other hand, the Regulation immediately preceding that, § 9767.6(a), requires the arrangement of a medical evaluation with an MPN physician "When the injured covered employee notifies the employer or insured employer of the injury or files a claim for workers' compensation". So under that version, notification could be enough. It is likely, and it should be the position of the defense, that the presentation of a claim form by the employee will be necessary in every case to trigger the obligation to provide medical care. However, there is an argument that under the Regulations as written, there is an obligation to provide care sooner if the employer has a network in place.

Along these lines, the *Honeywell* case (previously discussed) could become very important. There it was held that the ninety days for denial of claims under Labor Code § 5402 ran not from the date of notice, but from service of the claim form filed by the employee. Of course, there is no debate that under Labor Code § 5401, the employer is obligated to present a claim form to the employee upon notice of injury. *Honeywell* was careful to comment that under some circumstances of deceitful and egregious behavior by the employer, notice would be sufficient. The standards of this case may very well be found to apply to the obligation to provide medical care.

A failure to tender care may very well mean that the defense loses medical control. Labor Code § 4600(a) states that the defense is liable for the expense of medical care if it is not provided due to "neglect or refusal". The case law under the pre-SB 899 was not tolerant of refusal to provide care. These cases made it clear that refusal meant losing medical control. The cases on this are *Zeeb v. WCAB* (1967) 32 CCC 441 and *SCIF v. WCAB (Silva)* (1977) 42 CCC 493. These cases will be important precedent when applicants try to treat outside the network in these sorts of situations.

If medical control is lost due to failure to provide medical care, can it be reasserted by the defense? There is no certain answer. The *Zeeb* case cited above had the Supreme Court considering just this sort of issue; it ultimately held that the most vital interest in this sort of

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situation was to allow the applicant to continue within an established treating relationship. Such reasoning may be more questionable in the present environment, where the legislature obviously desired employer control, arguably as a result of the questionable care applicants had been receiving on their own.

It is certain that a continued refusal to provide medical care will entitle the applicant to treat elsewhere. Labor Code § 4600(a) specifies this. If a case is denied, then reasonable treatment outside the MPN will be justified if the issue of industrial injury is ultimately found in favor of the applicant. Denial thus becomes an even more serious decision for the adjuster, especially in the case where it is perceived that there may not be much permanent disability under the new schedule.

Changing Treating Physicians

The applicant may change primary treating physicians within the network. Regulation § 9767.6 allows this to happen freely, stating that at any point after the evaluation with the treating physician, "the covered employee may select a physician of his or her choice from within the MPN." Regulation § 9785 (b)(2) (at this writing still only a proposed Regulation) states that the applicant can only have one primary treating physician at a time, but that he or she can designate a new one at will, as long as there is still some need for medical care. Note that this does not explicitly limit the applicant to just one change; the only limitation is that the new physician be within the network, and that the change be made to a physician with the "specialty or recognized expertise" pertinent to the injury in question.

How many times can an applicant switch treating physicians? If there is no limit on this, it could wreak havoc when it comes to employer control. The applicant, if he or she is not getting their way, can simply switch doctors. As described below, there is a step by step process for resolving disputes over treatment written into the Labor Code. However, this hardly seems like it will be well used, as the applicant's better option may be just to change the treating doctor.

To add insult to injury, Regulation § 9767.6(f) specifies that the defense cannot make a request to change physicians. This is a serious departure from the prior system, and obviously leaves the defense in a very difficult position if a change is needed due to cause. Given the breadth of the panels in their current state, it may very well end up being the applicant who is in control in many cases. Note that this flies in the face of Labor Code § 4603, which allows the defense to petition for a change of primary treating physician directly with the Administrative Director. Only good cause must be shown. Also, Regulation § 9786 remains in place, outlining the procedures by which such a Petition is lodged. Certainly, the Labor Code trumps a Regulation, but the argument will be made that Regulation § 9767.6(f) pertains solely to where a network is in place, and is therefore allowable in those cases.

One of the distinctive features of SB 899 is that it left Labor Code § 4601 intact. As discussed under the topic of pre-designated physicians, this has led to trouble in more than one

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area. It declares that the applicant has the right to request a change in primary treating physician, and within five working days, the defense must tender the change. This troublesome section goes on to declare that the applicant has the right "in any serious case" to the services of a consulting physician, chiropractor, or acupuncturist. The defense will take the reasonable position that these must be within the network.

Applicant's attorneys may try one tactic here. They may request a change of treating physician, and when there is no timely response, demand treatment with a physician of choice outside the network. This seems incongruous with the applicant's right under Regulation § 9767.6 to simply choose a new physician within the network at will. The defense will argue that there is a standing response to any such request, given notification to the applicant of various physicians to choose from at the beginning of the process. The defense will also argue that Labor Code § 4601 does not apply where a network is in place. Note that Regulation § 9781 is enacted in regards to pre-designation under Labor Code § 4601. It specifies that it only applies where there is no network in place. The defense will look to this for support on the point.

Labor Code § 4601 is complimentary to Labor Code § 4600. The definitive case on the issue before SB 899 was passed was *Ralph's Grocery Company v. WCAB (Lara)* (1995) 60 CCC 840. This case was decided by the Court of Appeals, and confirmed the holdings of three prior writ denied cases; these had upheld, subject to reasonableness, the right of the applicant to switch treating physicians more than once. (This case provides an excellent exposition of the history of Labor Code §§ 4600 and 4601.) Significantly, this right was said to be found in the provisions of Labor Code § 4600, not just in 4601, which means that the applicant did not need to make a demand and await a tendering of a new physician name. The switch could simply be announced. § 4600 has changed, and there is no right to choose a treating physician outside the network, where a network exists. However, there is no reason to think that § 4601 does not still apply. The applicant will likely be found allowed to change physicians at will, and it is not hard to envision serious abuse of this principle.

A close reading of *Lara* confirms that the defense may be in trouble here. The Court suggested that if the right to change physicians was abused, the defense should simply avail itself of the remedies available at law. Since the defense can no longer request its own change of physician, these remedies are considerably narrowed. The *Lara* Court then went on to say that ". . . if there is widespread abuse by employees exercising their right to choose a physician, it is a matter that can be brought to the attention of the legislature."

There are other issues here. Labor Code § 4601 specifies that if an applicant requests a change of treating physician the defense is to tender a new name within five days. To some extent this is fine, as a name of a physician in the network may be tendered. However, such a quick response time can be hard to live up to on a daily basis. The specter is raised; will a failure to tender under § 4601 in a timely fashion result in a loss of medical control?

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There are a lot of cases which stand for the proposition that a failure to tender a new physician within five days when requested under Labor Code § 4601 does result in a loss of medical control. In *U.S. Flowers v. WCAB (Carranza)* (1997) 62 CCC 244 the Court found against the defense and imposed the cost of medical treatment of the applicant's physician where the defense did not respond to a change of primary treating physician. In *Pinkerton v. WCAB (Samuel)* (2001) 66 CCC 695 the response to the applicant's change of treating physician was not sufficient and control was lost. The principle that medical control is lost upon failure to respond to a request of physician is affirmed in *Hunt-Wesson Foods v. WCAB (Ortiz)* (1997) 63 CCC 85.

However, this case arose under a different statutory scheme altogether. While Labor Code § 4601 was not changed, the legislative intent of SB 899 seems to be that treatment be confined to the network. Accordingly, it is not clear that a failure to tender care following a request under Labor Code § 4601 will result in the ability of an applicant to treat outside the network. It is good practice to tender care in order to avoid this risk.

Proposed (at this writing), Regulation § 9785(b)(3) makes an attempt to deal with this to some extent. It provides that "If the employee disputes a medical determination made by the primary treating physician . . .the dispute shall be resolved under the applicable procedures set forth at Labor Code §§ 4061 and 4062. No other primary treating physician shall be designated by the employee until and unless the dispute is resolved." So there needs to be resolution of a dispute over treatment before the applicant can change primary treating physicians. This has long been the effect of this Regulation – rendering the applicant unable to select a new treating physician after P&S status, provided there is no future medical care warranted. There is an issue as to whether this applies where a network is in place, as discussed further below in our section on treatment and dispute resolution.

Chiropractors and Acupuncturists

Labor Code § 4601(a) still provides that the applicant is entitled to receive treatment from a chiropractor or acupuncturist in any "serious case". That really is disastrous choice of words by the legislature. Also, Labor Code § 4600(a) allows that the applicant is entitled to acupuncture or chiropractic treatment as reasonably necessary. Chiropractors and acupuncturists have traditionally been considered physicians in accordance with Labor Code § 3209.3(a), and have been allowed to serve as primary treating physicians in accordance with Regulation § 9785.

We have already seen that a chiropractor or acupuncturist cannot be pre-designated under Labor Code § 4600(d). This is only an issue of entitlement to treat outside the network by way of pre-designation. It seems that the applicant's general entitlement to treat with a chiropractor or acupuncturist within the network is preserved. Therefore, the networks need to have chiropractor and acupuncturist care available to applicants. In an advisory letter issued November 9, 2005, the DWC made it clear that it expected these to be on the panel.

Of course, treatment of this type is limited, no matter who the primary treating physician is. The 2003 legislation specified that an employee would be limited to no more that 24 chiropractic and 24 physical therapy visits per industrial injury. SB 899 similarly provides that an employee is entitled to no more that 24 occupational therapy visits per industrial injury. That language does not seem to solve many of the potential problems with the original statute. This is a modification of Labor Code § 4604.5(d).

There is a modification here to Labor Code § 4604.5(f). It is clarified to show that the defense can allow limited visits beyond the 24 allowed, and still allow for no further visits after that. That was a concern that has now been “cleaned up”.

Notice Requirements

When a network is created, notice to employees is required. Those employees who are fine, but will be subject to the network should they become injured, must be notified. The defense may also transfer currently injured workers into the network under certain conditions. There is a notice procedure for that too. Notice has become an important issue, chiefly because applicant’s attorneys sometimes claim avoidance of the network because of late or inadequate notice.

The Labor Code itself speaks of this issue. Section 4616.3 provides that the employer must notify the employee of his or her right to treat with a physician within the network "and the method by which the list of participating providers may be accessed by the employee". Along these lines, Regulation § 9767.6(d) in the context of a discussion regarding change of physicians within the MPN repeats the mandate of notification "after the first visit with the MPN physician". It also echoes the Labor Code’s requirement that the employee be provided with a list of participating providers and a method of accessing them. Neither of these provisions give time limits for notice.

More particularly, Regulation § 9767.12 is entitled "Employee Notification" and specifies two separate notification requirements.

It first concerns notification at the time an MPN begins. § 9767.12(a) indicates that notice must be given to "each covered employee in writing" about the use of the MPN. This is to be done thirty (30) days prior to the implementation of the MPN, at the time of hire, or when an existing employee transfers into the MPN, "whichever is appropriate to ensure the employee has received the initial notification."

It is also specified that an applicant is entitled to notification "at the time of injury". This does appear to require a separate notice. How much time is given to send the notice? This is unfortunately not made clear. As discussed further below, if the injury has already occurred at the time the network is created, notice is required if a transfer of care is attempted.

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Both sorts of notifications under Regulation § 9767.12 are required to be written in both English and Spanish. Also, there are a number of items (13 listed) required to be included in the notice to the employee. These collectively describe the virtual entirety of the MPN process. Applicant attorneys have taken pains to make a long list of demands for information and documentation when provided notice of the MPN. This is done in order to set up a claim of noncompliance with the notice standards, whether because they are not served timely or because they are not complete. The argument runs that failure to provide proper notice should result in the applicant being relieved from the obligation to treat within the network.

In particular is Regulation § 9767.12(a)(3). According to this requirement the notice is to advise the applicant how to review, receive or access the MPN provider directory. This goes on to say that "nothing precludes an employer or insurer from initially providing covered employees with regional area listing of MPN providers in addition to maintaining and making available its complete provider listing in writing". Applicant attorneys claim this means that the complete provider listing must be provided in writing upon request. They know that this is unduly burdensome on the defense because of the long list of medical providers available. If the defense takes a position that it is not required to provide the provider list in writing, and points out that all the information is available on a web site, equal protection arguments for destitute employees without computers are raised. Certainly, there will be an extensive amount of litigation in this area.

Will a failure to provide timely or complete notice result in a loss of medical control, thus allowing the applicant to establish a treating relationship outside the network? The law on this has not been decided. In accordance with the discussion under the topic of pre-designated physicians, there is at least one case in the past where it was held that a failure to provide notice was without real consequence. (*Albert Perez v. WCAB* (1999) 64 CCC 323; a failure to post a notice was not sufficient to cause a loss of medical control.)

Transfer of Care

The defense has the right under limited circumstances to transfer the care of an injured worker into the MPN. The applicant may of course choose the physician, but the care is transferred to a physician in the MPN. This is true regardless of the date of injury.

Labor Code § 4616.2 talks about something called the "continuity of care policy." It is specified in this Labor Code section that the applicant is to be allowed to complete the treatment being provided by a current provider only under some circumstances. If those are not met, transfer occurs. When a network plan is approved by the Administrative Director, the written Continuity of Care policy is to be filed and considered. The insurer or employer is to provide all employees entering the workers' compensation system notice of its written Continuity of Care policy and information regarding the process for an employee to request a review under the policy. Upon request, the defense has to provide a written policy to the public.

To supplement this Labor Code we are given two separate regulations. Regulation § 9767.9 is entitled "Transfer of Ongoing Care into the MPN". Another Regulation § 9767.10 is entitled "Continuity of Care Policy." These two Regulations are virtual mirror images of one another, and it is not exactly clear what the difference is between the transfer of ongoing care and a continuity of care. Perhaps continuity of care is meant to pertain to movements from one network to another or one provider to another rather than to a move from one primary treating physician to another. In any case, there is a well laid out system to describe what is supposed to happen in these situations.

If the applicant's original treating physician is already in the network, then obviously care does continue with that physician. The applicant is only allowed to retain treating physician services outside the network under four specified conditions. However, even if one of these conditions is met, the treating relationship existing outside the network can only go on for a year. The Labor Code and the Regulations repeat the four possible conditions word for word with only the most minor discrepancies.

1. He or she has an "acute condition". This is defined as a medical condition that involves a sudden onset of symptoms due to an illness or injury "or other medical problem that requires prompt medical attention and that has a limited duration." The Regulations specify that this means less than ninety days. This is obviously an extremely broad definition. It can mean a lot of things. The Statute concludes that "completion of treatment shall be provided for the duration of the acute condition."

2. A serious chronic condition will merit continual care of the original treating physician as well. This is defined as "a medical condition due to a disease, illness or other medical problem or mental disorder that is serious in nature, and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration." The Regulations define this as lasting more than ninety days. Once again, this is an extremely broad definition. Completion of treatment under this standard is not to exceed 12 months from the commencement of the employer network; the Regulations specify that this means one year from the notice of the network being provided to the employee.

   This statute says that completion of treatment is to be provided for a period of time necessary to complete a course of treatment, and to arrange for a safe transfer to another provider. Consultation is to take place between the insurer or employer and the injured employee and the former treating physician, and is to be consistent with good professional practice. All these general terms do not really give us much. The bottom line is that care is to continue unbroken to the extent possible, and not a year is to go by before transfer is complete.

3. A terminal illness. Completion of the treatment is to be provided throughout the illness until the point of death. Terminal illness is defined as an "incurable or irreversible

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condition that has a high probability of causing death within one year or less." There is no one year limitation explicitly spelled out here. If the applicant lives more than a year then presumably the treating relationship would continue. However, in that event the problem would have to be reassessed to see if it meets the definition of a terminal illness.

4. Performance of a surgery or other procedure that is authorized by insurer or employer. This surgery is to occur within 180 days of the establishment of the network.

Is there any situation that this does not cover? It seems clear that a very liberal standard is used. The Regulations supplement the statute, and it is hard to see how just about any injury would not qualify as either acute of chronic under these definitions. Perhaps it is the intention of the legislature to let applicants treat with their existing doctors for the first year, in almost all cases. If it cannot be wrapped up in a year, then the transfer is warranted. It is, ultimately, just a matter of time.

In any case, when the employer decides to make the transfer into the network, a notice is required. The applicant is to be notified that there has been a determination that one of the four exceptions does not apply. It is specified here that the notification shall be sent to the applicant's residence and a copy sent to the applicant's primary treating physician. That can be a little tricky in some cases where the applicant's primary treating physician is in dispute or has never been properly identified. The notification is to be sent in English and Spanish and is to "use layperson's terms to the maximum extent possible." Note that the extensive and detailed notice requirements of Regulation § 9767.12 (above) are not needed here. We are dealing with a much more simple sort of notice.

Once the applicant receives the determination, the applicant is to request a report from the primary treating physician that addresses whether one of the four exceptions apply. The Regulations go on to say "the treating physician shall provide the report to the covered employee within 20 calendar days of the request." If the treating physician does not provide the report, then the determination made by the employer stands.

I should point out that the key language here is unfortunately not as precise as one would like it to be. The treating physician's report is not due until 20 days after the applicant makes the request. There is no designated time period for the applicant to make the request. This leaves an avenue open for applicant attorneys to make a request arguably at any point. It likely will be found at some point that the applicant must make the request within a reasonable time period. At some point, the issue is forced, because the defense will refuse to authorize treatment after the determination is set. Right now, most defense attorneys seem to be taking the position that if there is no response from the treating physician within 20 days from notice to the applicant, that the transfer is deemed proper. It is also a problem because if the applicant does request a determination by the treating physician, it is not necessarily required that the defense receive notice that the request was made. This could lead to a lot of confusion and issues of fact on the point.

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Note that the statute itself contains language referring to the continuity of care concept that add some confusion, and that are not dealt within the Regulations. The defense can require the former treating physician to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination. This of course assumes a specific contract. If the former provider does not agree, the care does not have to continue. That seems problematic if an injured worker is caught in the middle. The defense can agree to provide continuity of care beyond these requirements. It is not obligated to continue treatment with a provider whose contract has been terminated or not reviewed for reasons relating to medical disciplinary cause or reason. Rates and methods of payment are to be continued per the original contract, or as what would be applicable in a similar geographic area. These terms seem to apply to a transfer from one organization to another, perhaps one network to another, rather than to a transfer of care to a new doctor. As noted above the distinction is unclear.

C. Treatment and Dispute Resolution

The legislature has provided for an exclusive resolution process for disputes over treatment that arise within a network. If an applicant disputes either the diagnosis or the treatment prescribed by the treating physician within the network, he or she may seek an opinion on the issue with another physician within the network. A third opinion may also be sought, and if that is not acceptable, one more medical opinion is allowed. This last opinion is performed by a physician selected by the Administrative Director, called the Independent Medical Reviewer, or IMR (also known informally as the “super doctor”).

It appears that this process of resolution is exclusive. Labor Code § 4616.6 states “No additional examinations shall be ordered . . . and no other reports shall be admissible to resolve any controversy arising out of this article.” That would exclude the medical legal process in its entirety. What is a “controversy arising out of this article”? The article describes the creation and implementation of networks, and includes the dispute resolution process where the applicant disagrees with proposed medical treatment or diagnostics. Arguably, the scope of this language is meant to pertain to disputes over medical treatment. It is not clear that it pertains to other issues. If this language were to be read too broadly, it would eliminate the medical legal process in its entirety for any issue where a network is involved. It is doubtful that is what was intended.

A poignant issue is how this provision relates to the longstanding Regulation § 9785. This Regulation has long stood for the idea that a change in treating physician could not be made after P&S status, unless the medical legal procedure under Labor Code §§ 4061 and 4062 were done first. As noted above, the newly proposed Regulation says about the same thing. Given the language of this statute, it may well be that this sort of dispute falls under the purview of Labor Code § 4616.6. However, it is far from certain that the issues of P&S status, change of treating physician and entitlement to future medical care are confined to the network statutes.

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Note, that this is on the face of it a benefit to the defense, as it confines the applicant's ability to contest treatment issues. On the other hand, this can also be hard on the defense, who is not given the right to initiate this process. The defense cannot ask for a change of treating physician as described above; nor can the defense turn to the medical-legal process, at least as to treatment issues. It seems the defense gets medical control, but is also stuck with the doctor selected by the applicant.

This resolution process is described in Labor Code §§ 4616.3 and 4616.4. These are further explained by Regulation § 9767.7. There are extensive Regulations dealing with the process of selecting, monitoring and implementing the IMR; these are Regulations §§ 9768.1 through 9768.17.

In the event of dispute over treatment or a diagnostic, the employee is supposed to choose the physician with the appropriate specialty or expertise in treating the particular condition. Regulation § 9767.7 lays it out nicely. The applicant is responsible for notifying the employer of the dispute, selecting a doctor from the list, making an appointment within sixty days, and informing the defense of the appointment. The defense is to provide a "regional area listing" of providers or specialists as appropriate to the applicant, inform the applicant of his or her right to see the records that will be sent to that physician (and provide them if requested), and send the records to the second opinion physician, along with written notice of the nature of the dispute (with a copy to the applicant). If the applicant does not make the appointment within sixty days of getting the list, the objection is waived.

If the second opinion physician determines that the issue is outside the scope of that physician's expertise, notice is to be sent so that a new doctor can be picked. If the applicant gets his or her way, the defense is not given the ability to continue the process by selecting the third physician. (The defense presumably could depose that physician and bring the case to the Board for an expedited hearing.) If the applicant does not get his or her way, the process can be started all over again and a third treating doctor can be selected. If after that the applicant does not get his or her way again, an IMR may be selected. The process for selecting the IMR is set out in Regulation § 9768.9. Notice of the process and a form is to be sent to the applicant at the time the third treating doctor is selected.

Note that the second or third physician may schedule diagnostics if deemed necessary. If the dispute is over something like an MRI, the dispute process itself may resolve the issue. Recommended treatment by these doctors is to be performed within the network.

The next step of review in the event of a dispute over medical treatment is the newly established IMR process. The Labor Code and Regulations have a tremendous amount to say about how this program is to be handled.

These must be licensed physicians, but are not necessarily QMEs. The Administrative Director is to contract with individual physicians or an independent medical review organization

to perform these reviews. The Administrative Director is responsible to make sure that these doctors are credentialed and privileged and that the reviews provided by the medical professionals are timely, clear and credible. He or she is to be sure that medical professionals who provide a fair and impartial panel are selected, that confidentiality of medical records is respected, and that there is no conflict of interest. All individuals selected must be licensed physicians, and in a particular case, the medical professional is to be knowledgeable in the treatment of the employee's medical condition, knowledgeable about the proposed treatment, and familiar with the guidelines and protocols in the area of treatment under review. The physicians are also to hold a current certification by a recognized American specialty board. Their license does not have to be in California. Each medical professional is to have no history of disciplinary action or sanctions, or be "under accusation" by a licensing agency. The Administrative Director keeps a list of IMRs, signs two-year contracts, and can put IMRs on inactive status or remove them for good cause.

The Administrative Director upon receipt of the form signed by the applicant selects the IMR. The applicant can request an examination, or a report based upon the records, and may request an alternate specialty from that of the treating physician. The applicant can object within ten days if there is a conflict of interest. The Administrative Director can also replace the IMR if it is found that the wrong specialty was used. Again, the applicant has only sixty days to schedule the exam or the dispute is waived; if there is a missed appointment, he has five days to reschedule. The defense is to schedule interpreters and medically necessary transportation.

The applicant can provide any relevant material or documentation with the application. The defendant can and must provide the reviewer with information "that was considered in relation to the disputed treatment or diagnostic service" and "all relevant medical records". The applicant receives copies. The Labor Code specifies that this can include:

"1. A copy of all correspondence from and received by any treating physician who provided a treatment or diagnostic service to the injured employee in connection with the injury.

2. A complete and legible copy of all medical records and other information used by the physicians in making a decision regarding the disputed treatment or diagnostic service."

The medical reviewer then conducts the examination. He or she is to do a physical examination. He can order any diagnostic tests necessary. He or she is to utilize the Utilization Schedule and make a decision about the proposed diagnostic or treatment. The reviewer issues a report to the Administrative Director within 20 days of examination, unless there is a serious threat to the health of the applicant, when the report is to be expedited and rendered within three days of the examination. A serious threat to the applicant's health is loosely defined as "including but not limited to serious pain, the potential loss of life, limb or major bodily function, or the immediate and serious deterioration of the injured employee." The

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Administrator can add on up to three days to the three-day period in extraordinary circumstances for good cause. The IMR cannot treat the applicant except in an emergency.

The report is to be complete and standards are specifically set out in Regulation § 9768.12. Whether or not there are special considerations, the Administrative Director upon receipt of the reporting is to "immediately" adopt the determination of the reviewer and issue a written decision to the parties. That means, according to Regulation § 9786.16, within five business days.

If the applicant wins, and the disputed treatment or diagnostic service is awarded, he or she can get it from a physician outside the network, and the defense is liable for the cost. The treatment outside the network is limited to that in dispute, per Regulation § 9768.17. The defense is boxed in at this point. Since the report is to be in line with Utilization Guidelines, there would seem to be nothing stopping a doctor's deposition and an expedited hearing. Nevertheless, this structure remains designed to tightly control any disputes over medical treatment.

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4. Medical-Legal Procedure: A Whole New World

For a long time Labor Code §§ 4060, 4061 and 4062 governed the medical-legal process in Workers' Compensation. While those sections as modified remain, the medical-legal procedure as we know it has changed radically. To put it succinctly, the dueling QME aspect of the process has now ended. In every case, only AMEs and panel QMEs will be allowed. The Labor Code §§ 4061 and 4062 are now eviscerated; they along with § 4060 make reference to a couple of new statutes. These are Labor Code §§ 4062.1 and 4062.2, and they form the heart of the medical legal process.

The process used to center around the distinction between accepted and denied cases. Now the process is divided primarily by represented and unrepresented workers, regardless of whether the case was denied. Labor Code § 4062.1 deals with unrepresented cases, and, put simply, requires the use of a panel physician in every case. Labor Code § 4062.2 deals with represented cases, and requires the use of a panel physician where the parties cannot agree to an AME.

There is an exception to the general process. As explained herein, where an applicant is treating within the network, there is a specified process for resolution of treatment issues. That process is exclusive, and medical legal evaluations are not allowed in those cases.

A. Application of the New Standard

The new medical-legal process in represented cases is specifically stated to apply only to those injuries with dates on or after January 1, 2005. This was confirmed in the case of *Larios v. WCAB* (2006) 71 CCC 430. Thus it is different than most of the provisions of SB 899. For those cases where the applicant has no lawyer, the new statutes take effect for all dates of injury (this is discussed below.)

Ghost Statutes

A special problem arose here for represented cases. SB 899 repealed the older versions of Labor Code §§ 4060, 4061 and 4062. This was effective April 19, 2004. Since the new statutory scheme did not come into effect until the end of that year, this left a period in between where there was no established medical legal procedure. Some decided to use the previous §§ 4060, 4061, and 4062 for all dates of injury until January 1, 2005. For dates of injury between April 19, 2004 and January 1, 2005, these became known as the "ghost statutes". There was a question as to whether the repeal of the old statutes left all cases before 2005 without any medical-legal procedure.

This issue was confronted by an *en banc* decision in a case called *Simi v. Sav-Max Foods*, (2005) 70 CCC 217. There the WCAB decided that the old statutes would remain in effect for

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dates of injury before January 1, 2005. This decision was not left alone by applicant's attorneys. Some cases were delayed; however, after a lengthy appeals process, the philosophy of *Simi* was confirmed in the sister cases of *Cortez v. WCAB* (2006) 71 CCC 155 and *Nunez v. WCAB* (2006) 71 CCC 1616. Thus, the law is clear now. For injuries before January 1, 2005, the old medical-legal process remains in place. For those claims with a later date of injury, the new process applies. The law, it seems, at least in this case, is not an ass.

Obtaining Multiple Reports

The new sections are careful to guard against medical-legal reporting outside the scope of §§ 4060, 4061, and 4062. All three specifically prohibit evaluation of their respective medical-legal issues except by Labor Code §§ 4062.1 and 4062.2 (see Labor Code §§ 4060(c) and 4060(d), 4061(i), and 4062.9(a).) These just about cover every issue. Also, Labor Code § 4062.5(j). contains language formerly present in the three main sections. The parties "to the extent possible" are to use the same panel QME or AME when a new medical dispute arises on a case. This is reiterated in Regulation § 30(d)(2). The idea seems to be that there is only one forensic evaluator allowed on every case.

To some extent at least this stands in contradiction to various Labor Codes that seem to allow parties to obtain medical-legal evidence at will. Left unchanged by SB 899 was Labor Code § 4064(d), which provided for the employer to be liable for legitimate medical-legal expenses under §§ 4060, 4061 and 4062, and stated that "However, no party is prohibited from obtaining any medical evaluation or consultation at the party's own expense." There is also general authority for parties or the WCAB to obtain medical-legal reports in Labor Code §§ 4050, 4621, 4622, 5701, and 5703.

In both *Cortez* and *Nunez.,* the Court is supportive of the exclusivity of §§ 4060, 4061, and 4062. The defense in each of those cases had suggested that the reports in question would be admissible under Labor Code § 4050, and in *Cortez*, they pointed out that the Judge could order the evaluation under Labor Code § 5701. Note that the arguments were being made that these sections could be utilized under the standards of the old system, not the new one. There does not seem to have been an argument made that these alternate sections would apply where the new system is in place. Nevertheless, the comments of the Court were instructive as to their likely attitude going forward on this issue.

In particular, Labor Code § 4050 does allow the defense to require the applicant to submit to intermittent medical examinations. The Court in *Nunez* made reference to the interpretive history of § 4050, citing *Regents of the University of California v. WCAB* (1995) 60 CCC 1246. There it was held under the old medical-legal structure that an in pro per applicant, having already had a medical-legal examination under Labor Code § 4061, could not be forced to attend a rebuttal examination by the defense under Labor Code § 4050. In that case, the matter was returned to the WCAB to see if such a rebuttal might be appropriate under Labor Code § 5703.5, a section that along with § 5701 allows the Board to order further medical-legal reporting.

It seems there has never been a firm decision by the courts of when evaluations under Labor Code § 4050 may be required of the applicant or when they are admissible. *Nunez* carefully concluded that in represented cases Labor Code § 4050 could not be used to "circumvent" the exclusive process. *Cortez* was even more blunt, stating that ". . . § 4050 may not be utilized to circumvent the medical evaluation and reporting procedure of former § 4062. " *Cortez* also prohibited the use of § 5701 in this regard. Accordingly, entitlement to medical-legal reporting may be even more circumscribed under the new system than it was under the old.

This issue is likely to see litigation. In light of the demand that panel QMEs be used where AMEs cannot be agreed upon, it is quite likely that panel QMEs will be used frequently. There is a strong possibility that many of the reports written by these often inexperienced physicians may not serve as an adequate basis for decision or resolution, and this will spur parties to find arguments why further evaluations may be obtained. There is likely to be an increase in the number of cases where the record will need to be developed. It is unlikely that the WCJ's duty to develop the record in accordance with *McDuffie v. WCAB* (2002) 67 CCC 138 will change. Some specific problems with these panel QMEs are discussed in more detail below.

B. Medical-Legal Procedure

Labor Code § 4060

Labor Code § 4060 still applies to denied cases. The original language of this part of the statute remains: "This Section shall not apply where injury to any part or parts of the body is accepted as compensable by the employer." However, where the parties used to select their own QMEs, now only panel QMEs and AMEs are allowed. This is significant, in that a defendant who feels a case is a fraud is not allowed to obtain a defense QME.

Labor Code § 4060(c) provides that if ". . . a medical evaluation is required to determine compensability . . ." and the applicant is represented by an attorney, then the procedures set up in Labor Code § 4062.2 are utilized. Those are described below. If the applicant is not represented by an attorney, then the procedures in Labor Code § 4062.1 are utilized. That is also described in further detail below.

Labor Code § 4060.9(d) does demand in an unrepresented case that the defense provide the applicant with notice, either that a comprehensive medical evaluation is needed to determine compensability, or notice that liability is not accepted, and that the employee has a right to a medical evaluation. Also, § 4060(e) indicates that the applicant is to be notified of his rights to speak to an Information and Assistance (I&A) officer and to have an attorney. Specified language is utilized here. The notice to the applicant is to be accompanied by the form that is prescribed by the Administrative Director for requesting the assignment of a panel doctor.

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There has never before been a requirement under this section that an objection issue to the treating physician, or that the parties negotiate for an AME, before a QME is obtained. There still is none in Labor Code § 4060. However, as noted below, there is a requirement in represented cases under Labor Code § 4062.2. that an AME be solicited.

Labor Code § 4061

Labor Code §§ 4061 and 4062 still deal with accepted claims. They are dramatically scaled back, however, and ultimately make reference to Labor Code § 4062.1 or § 4062.2, which, again, are described below. Labor Code § 4061 still deals with situations where temporary disability in an accepted case is coming to an end. It still provides that notices need to be sent to the applicant that permanent disability is not being paid, is being paid in a defined amount, or may be paid.

Labor Code § 4061(c), which applies when the applicant is represented by an attorney, changes dramatically. No longer is an AME to be sought by the parties under this section. Rather medical evaluations are to be obtained only as provided in Labor Code § 4062.2. Subsection (d) of Labor Code § 4061 applies where an applicant is not represented by an attorney. If the parties do not agree on the permanent disability rating, the form is to be provided to the unrepresented applicant to refer him or her to a panel physician. Either party is allowed to request a panel physician in accordance with Labor Code § 4062.1. The remaining provisions of Labor Code § 4061, describing how a panel physician is to be handled, are left in place.

Like its predecessor, this section does not require the defense to object to the opinions of the primary treating physician. Nor does it require a negotiation for an AME, although per Labor Code § 4062.2 (below) this negotiation is required in represented cases. We are left with essentially the same situation. Along these lines, it is important to keep in mind the case of *Strawn v. Golden Eagle* (2000) 29 CWCR 105, in which it was held that under the old system an objection must issue before a QME could be obtained, within a reasonable time period. (The defense had waited four months to object.) It remains to be seen how this sort of concept will play out under the new system.

Labor Code § 4062

Labor Code § 4062 still complements its predecessor section, by dealing with situations where either the applicant or the defense objects to a medical determination made by the treating physician concerning any medical issues not covered by § 4061.

This remains the only section which still requires an objection to the opinion of the treating doctor's reporting before a medical-legal report may be obtained. The time limits are the same, (i.e., twenty days for a represented worker and thirty for an unrepresented one). No longer does this Statute require that the parties seek an AME. In fact, that entire language is eliminated.

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The Statute simply makes reference to Labor Code §§ 4062.1 and 4062.2 (which does require this discussion), and notes that no other medical evaluation is allowed to be obtained.

Added here is a provision that issues covered by § 4610 – the utilization review statutes - are not covered by Labor Code § 4062, with one exception. New language here says that if the applicant objects to a decision made pursuant to § 4610, to modify, delay or deny a treatment recommendation, the employee is to notify the employer of the objection in writing within 20 days of receipt of that decision. However, one is given to wonder as to the implications of the applicant's failure to object in a timely fashion.

The entirety of Labor Code § 4062.1 has been repealed. That provision was part of the 2003 legislation and appears to have been superfluous in regards to Labor Code § 4062.

Labor Code § 4062.1

This section applies if the applicant is not represented by an attorney. Of special note is the fact that this section does not specify that its procedures are limited to injuries of any specific date. This is in contrast with Labor Code § 4062.2, which applies only to injuries occurring on or after January 1, 2005. Since emergency legislation was enacted, it appears that the medical-legal procedure for an applicant who is not represented by an attorney has been changed from April 19, 2004 onwards, for all dates of injury, as long as the medical legal procedures have not yet been initiated.

According to Labor Code § 4062.1, either party can request the medical evaluation, whether the case is accepted or denied. The form prescribed by the Administrative Director that requests a panel of three qualified medical evaluators can be submitted by either side. However, the defense cannot submit the form unless the employee has failed to submit it him or herself within ten days from the defense tendering it to the applicant.

Once the panel of three doctors is submitted, the applicant has the first bite of the apple when it comes to picking the doctor. Under Labor Code § 132.2(h)(1) if the panel is not assigned within fifteen "working days" after receipt of the request, the applicant can pick the QME. This is a severe disadvantage for the defense, especially when there is an applicant attorney surreptitiously giving advice and waiting to enter representation. (Note that there is no choice to a QME where the assignment of the panel is late and the applicant is represented.) The panel of three is sent to both parties. If within ten days the applicant does not select a particular physician, the defense can do it. Thereafter, the defense will set the appointment for the applicant as well. Either way, travel expenses must be forwarded.

Interestingly, there is a provision here giving the applicant an "out," when dealing with the independent evaluator. The evaluator has to give the applicant a chance to ask questions concerning the evaluation process and the evaluator's background. The applicant is then supposed to submit to the evaluation as requested. However, if the applicant has good cause to

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terminate the evaluation, the applicant may do so. Good cause is defined as "evidence that the evaluator is biased against the employee because of his or her race, sex, national origin, religion or sexual preference, or evidence that the evaluator has requested the employee to submit to an unnecessary medical examination or procedure."

If the applicant declines to proceed with the evaluation, he or she has the right to a new panel of three qualified medical evaluators, and the process presumably starts all over again. This presents a bit of a conundrum, as one can imagine an applicant refusing over and over again to participate in these medical-legal evaluations. If the Appeals Board later determines that the applicant did not have the good cause necessary, the cost of the evaluation is deducted from the award.

Once a panel physician has been obtained, no further medical evaluation will be allowed to go forward, even if the applicant gets an attorney later on in the case. That is a change from Labor Code § 4064(b), enacted in 2003. Originally, if an applicant got a panel QME no further medical-legal evidence was allowed, even if the applicant obtained an attorney. In 2003 that was changed, allowing the applicant to jump medical-legal tracks after retaining a lawyer, and to obtain further medical-legal evidence. Now the restriction is back in place. The language of § 4064(b) remains, but seems compatible with the new exclusive standard.

Labor Code § 4062.2

The former § 4062.2 is repealed in its entirety; it had specified how the parties were to handle providing information to doctors. The new section lays out the rules for proceeding in every case where the applicant is represented by an attorney.

First, a written request to obtain an agreed medical evaluator is to be made. That written request is to name at least one proposed physician. Ten to 20 days are allowed for agreement to be reached. If this fails, either party can request the assignment of a three-member panel of qualified medical evaluators. The party submitting the request designates the specialty of the medical evaluator. However, they are supposed to provide information, including the specialty of the medical evaluator requested by the other party and the specialty of the treating physician. Copies are to be served on the other party.

Within ten days of the assignment of the panel, the parties are supposed to confer and see if they can agree on one of the names to be an agreed medical evaluator. If they cannot agree by the tenth day, each party is supposed to strike one name from the panel. Naturally, the question arises as to who has to make the first decision to strike a name. In any case, the third and remaining doctor will be the sole medical evaluator for the case. It is provided that if one party fails to exercise their right to strike a name within three working days of gaining the right to do so, the other party can select the QME on their own.

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As with unrepresented employees, a represented applicant is to be responsible for setting up the appointment. However, if the applicant fails to do so within ten days after the selection of the panel physician, the defense is to make the arrangements.

Labor Code § 4062.3: Communication with Panel QMEs

This new section and Regulation § 35 specify how information is to be provided to any qualified medical evaluator. It is substantially the same as the former § 4062.2, which had set the standard for communications with an AME. Now the same standards apply to both AMEs and panel QMEs. It is well known that parties in Northern California tend to go by the Code when communicating to AMEs. Each side writes their own letter explaining their position, and provides service of their own evidence. In Southern California a joint letter is usually used, with a list of attached documents enclosed. This, while a difference, in form does not appear to be unlawful. Perhaps the South will change its ways.

Ex parte communication with a panel doctor or AME is strictly prohibited. The parties are to write the doctor about their position, and this writing is to be served on the other party twenty days before the evaluation. Parties may send evidence, medical or non-medical, to the physician. However, this must be served on the other party twenty days before being sent to the physician. The opposing party may object to non-medical evidence within ten days, and ". . . thereafter, the records shall not be provided to the evaluator." Obviously, this last item is a problem, as the defense often has non medical evidence to present that is vital to the case, such as sub rosa, or witness statements.

A panel report has been excluded for improper ex parte communication. In *Forsythe and Associates v. WCAB* (2004) 69 CCC 396, the defense had sent videotape to the doctor without first providing it to the applicant. An AME report was excluded in the case of *Vons Companies v. WCAB (Leone)* (1997) 62 CCC 838. There is no further significant law on this topic. It is hard to visualize this sort of evidence ultimately being excluded from the attentions of the doctor; if worse came to worst, a WCJ would almost certainly have to order it. These sorts of issues will likely come to prominence given that more litigated cases will now be seen by panel QMEs.

Upon completing the evaluation, the medical evaluator will summarize the medical findings in a form prescribed by the Administrative Director. This is then to be served on the parties, and is to contain an answer to all contested medical issues. If after the medical evaluation is prepared either party objects to any new medical issue, they are to return to the original evaluator to the extent possible.

Report Timeliness

Under Labor Code § 4062.5 and Regulation § 38, if an AME or QME selected from a panel fails to complete an evaluation within the time frames of Labor Code § 139.2 a new

evaluation can be obtained upon the request of either party. Section 139.2 allows 30days from the exam date to submit the report, with allowances for extensions in special circumstances, as currently outlined in Regulation § 38.

Before SB 899, this section only allowed the unrepresented applicant to object to an untimely report. Now the option is extended to the defense. This may well be used as a tactic, given that cases with higher exposure and litigated cases are now being presented to a panel doctor.

Regulations and Issues

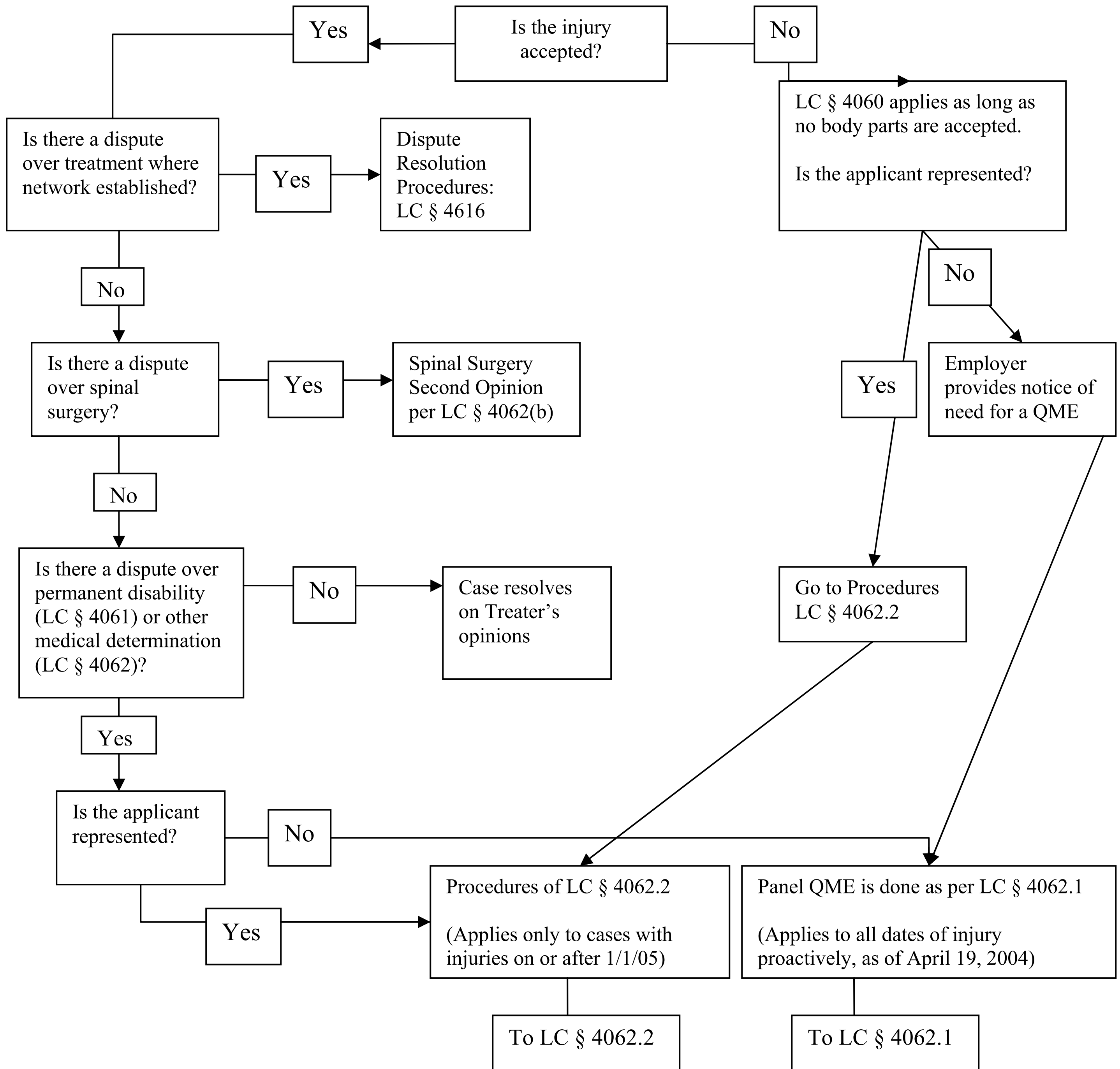
The legislature changed the Labor Code, but thus far, there has been no change in the corresponding Regulations. We therefore have been stuck with Regulations §§ 30 through 39.5 for guidance. These were written for the old former medical legal system, where panel physicians were used only where the applicant was representing himself. Most of the provisions here refer to the applicant as in pro per, and are accordingly often more confusing than helpful. This area desperately needs revised Regulations; to this point the workers' compensation community has had to make do.

To request a panel of three physicians parties have had to use the old form 106. This form and its attachments are written for the unrepresented worker; there is a lot of inappropriate language for a represented case. Regulation § 31.5 allows the applicant to request a second panel physician under some circumstances (i.e., incorrect specialty, inability to schedule in sixty days, the employee has moved out of the area, etc.). Regulation § 33 also allows the applicant to request to reschedule the QME if under some circumstances that doctor is unavailable. However, there is no remedy for the defense in these sorts of situations.

The process as described in the Regulations is geared toward more straight forward matters. Complex litigation can present special challenges. For example, there are often cases with multiple diagnosis or multiple body parts injured. There is no particular Regulation that handles the situation where more than one medical-legal opinion is needed. Under the former law, multiple medical-legal examinations were allowed for different specialties in accordance with the statutes and a case called *Gubbins v. Metropolitan Insurance Company*, (1997) 62 CCC 946.

Now things are quite uncertain, and to make matters worse, in our experience the DWC Medical Unit will not give more than one QME in any case. Presumably, the panel QME is to refer the applicant out for examination with other specialists that the panel doctor selects as needed. Surely at some point this will be the subject of litigation if enacted Regulations do not fix it. Pursuant to Labor Code § 132.2(h)(4), the medical director is to determine the type of specialist selected on the form is appropriate. Presumably then a judgment is made, which may be questionable in a complex file.

MED-LEGAL PROCEDURE UNDER SB 899



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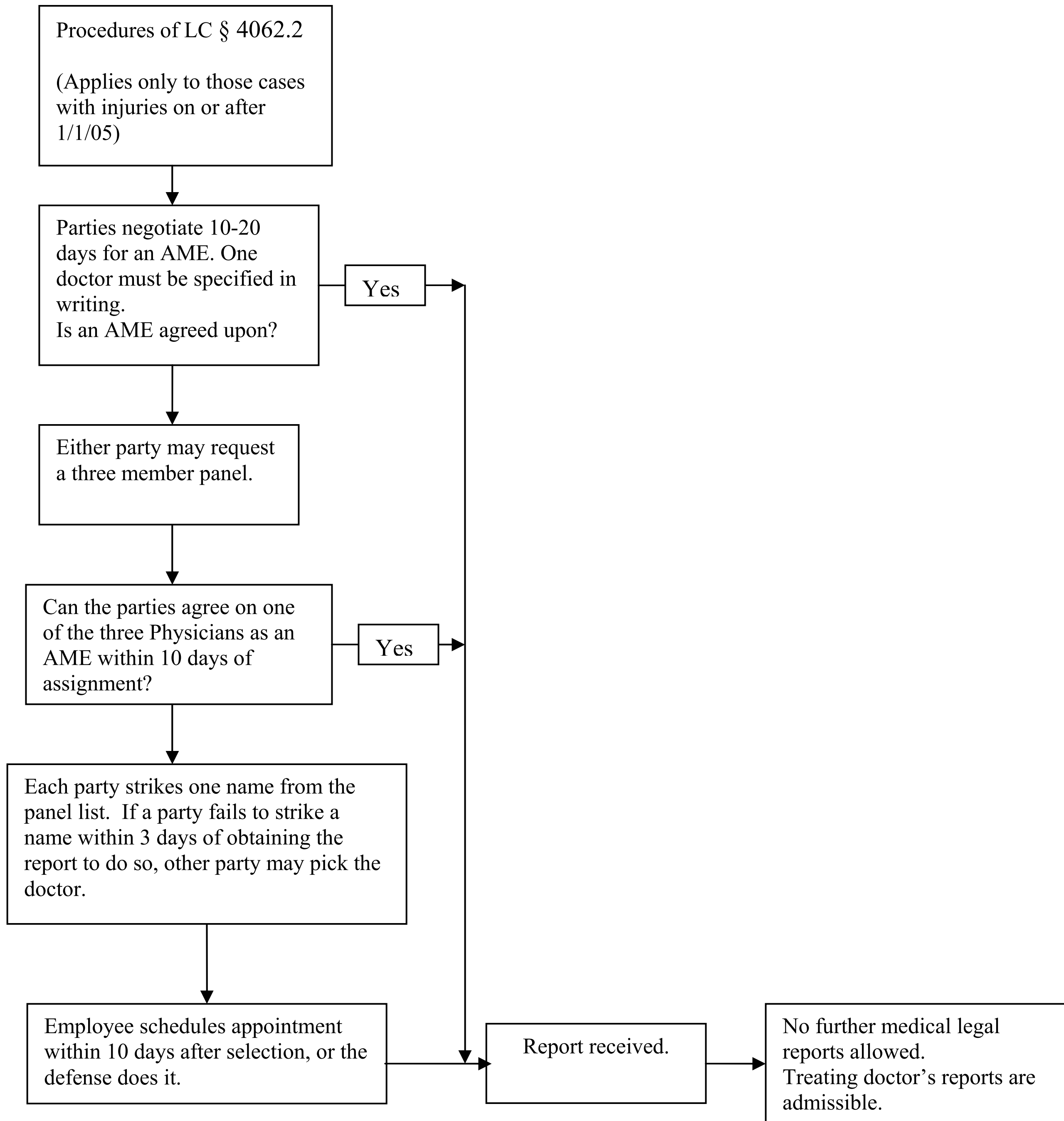

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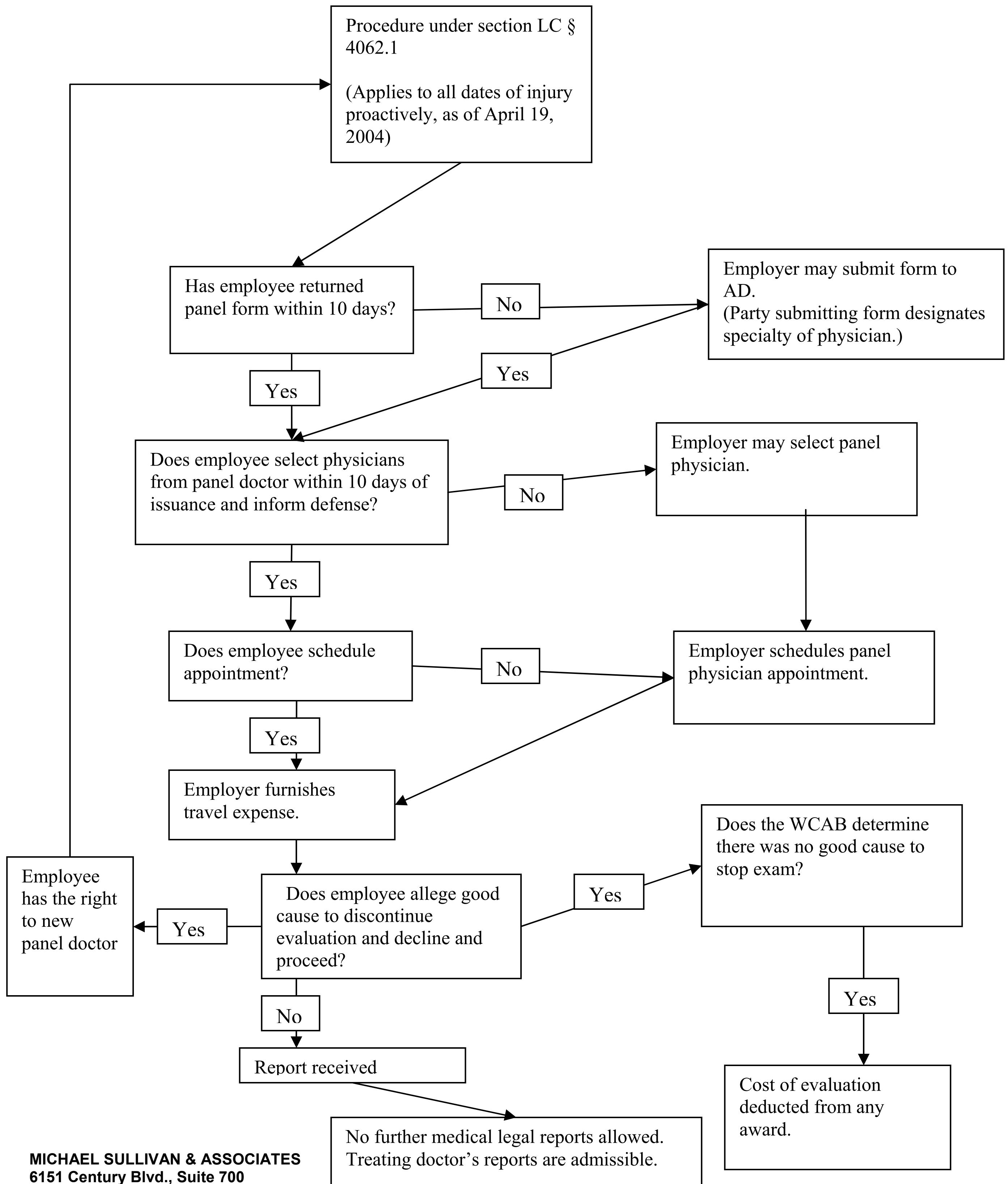

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05. Limitation of Temporary Disability

Labor Code § 4656, which had previously provided that temporary disability (TD) could not extend for more than 240 weeks within a five year period from the date of injury, has been modified. A new statute describes a two year limitation to the payout of TD, and it explicitly applies only to those dates of injury which occur on or after April 19, 2004.

The Two-Year Limitation

For those dates of injury, there is a new standard for TD payments. Labor Code § 4656(c) states that "Aggregate disability payments for a single injury occurring on or after the effective date of this subdivision, causing temporary disability shall not extend for more than 104 compensable weeks within a period of two years from the date of the commencement of temporary disability payment."

What does this language mean? Obviously, this is intended to limit payment of TD. However, it has been pointed out that this section does not limit the payment of TD from the date of injury, as had been done previously. Rather, TD is limited from the date of the first payment made. Therefore, it appears that this limitation will not begin to run until the first payment of TD has been made.

This has the potential to be a serious distinction. Usually TD begins right after the injury occurs, and in that case the two year limitation would run smoothly. However, it is not hard to visualize a scenario where TD begins well after the date of injury – even years after. Suppose a person who left an employer several years prior files a claim, and requests back TD from more than five years from the date of injury itself. Will that person then be entitled to the back owed amounts, and going forward another two years?

We do not know for certain, but it does seem that back TD will be owed, and the two year limit will only begin when the first payment is made. There are two reasons to draw this conclusion. First, is the literal language of this statute. The language only speaks to what happens after TD commences, and makes no reference at all to what happens before that. Secondly, the California Workers Compensation Institute in May 2004 published a Bulletin. This describes how they were asked to consider, before SB 899 was passed, the implications of limiting TD. The last item they were asked to consider was the possibility of capping TD two years after the initial payment date. In the Bulletin, this is distinguished from such possibilities as beginning the cap from the date of injury, or the date that TD was actually owed. Statistics were given describing the "lag" between when TD would be owed and when it actually commences. The legislature seems to have made a deliberate choice to start the cap from the date TD begins. Perhaps this is meant to ensure some level of fairness to an applicant who is not paid this benefit in accordance with the law.

In any case, this gives the defense an incentive not to delay TD lightly. Once it begins, an assurance is given that it will end in relatively short order.

Also, it is difficult to discern what is meant by "104 compensable weeks within a period of two years". Does this along with the language describing "aggregate" payments mean that the applicant gets 104 weeks in total, regardless if it is paid in broken periods, even exceeding two years from the initial payment of TD? It seems not. The language of the statute is very clear. TD Payments are not to go forward following two years from the initial payment. The statute is bit confusing, as 104 weeks is two years. It may well be that this language is superfluous. The statute to be clear should have just stated that TD is not allowed two years from the commencement of payments, and left it at that. It is certain that we will eventually see case law interpreting this.

This does seem to have potential for a serious effect on Labor Code § 4661.5. This section had codified a longstanding legal principle: that payment of temporary disability made more than two years from the date of the injury is to be paid at the rate in effect at the time of the payment. This principle will have no force for those cases with a date of injury occurring on or after April 19, 2004, when TD starts immediately after injury. It will have a significant effect on most claims. This is especially important in light of the benefit increases enacted in recent years.

Exceptions

Exceptions are made. Any employee who suffers from specified types of conditions has up to 240 aggregate weeks within a period of five years from the date of injury, as per the original law. These conditions are:

A. Acute and Chronic Hepatitis B

B. Acute and Chronic Hepatitis C

C. Amputations

D. Severe Burns

E. Human Immunodeficiency Virus (HIV)

F. High Velocity Eye Injuries

G. Chemical Burns to the Eyes

H. Pulmonary Fibrosis

I. Chronic Lung Disease

Commentary and Debate

Thus far, we have seen nothing on this from our courts. Only the most recent dates of injury would be the subject of this new rule up to this point. However, we have had plenty of commentary. This portion of the reform has been described as one, if not the single most, harsh provisions of SB 899. It is not difficult to envision a very seriously injured applicant, perhaps one with a failed back syndrome that requires multiple surgeries, left without this benefit while still treating. It appears that the legislature may have intended to shift the burden in these sorts of cases to the federal system; it may have been contemplated that these sorts of special cases would be in position to receive social security. Granted, this is less money generally speaking than the typical TD benefit.

With no more vocational rehabilitation and no more VRMA, applicant's attorneys will be looking for proof of total permanent disability on expedited basis for cases like these, and may even delay surgery to achieve this. It is not inconceivable that an applicant, faced with the end of TD, will return to work, only to have a new specific injury right away. This sort of scenario is already familiar to defense attorneys even without these new circumstances. False injuries as always should be denied.

If there is one overarching problem with the California system, it is the delays. Doctors, who in the past have often seemed to treat only to generate bills, are among the worst offenders. Applicant attorneys often feel at their mercy. Certainly, the new medical legal system, where AMEs are likely to predominate, it will not be helpful. However, this new limitation on TD is virtually certain to force treating doctors and applicant attorneys to make sure these files are moved. This may also help to alleviate unnecessary medical care, and opportunism in that area. Our perspective is that in the vast majority of cases this will be a helpful rule.

Anticipated Strategies

How will applicant's attorneys get around this? It is not hard to visualize a few tactics that will be used. Obviously if one of the explicit exceptions is available, it will be used. Also, it is likely that there will be where possible multiple dates of injury filed. The argument will then be that TD is owed for one date of injury at a time. The defense is certain in this case to argue that TD for more than one date of injury will run concurrently, especially where viable medical evidence makes it obvious that the applicant did not suddenly stop being TD for one injury and begin to need this benefit because of another.

The actual date of injury here will in some cases become even more important than it already is. As is well known, and well explained in landmark cases like *Western Growers v. WCAB* (1993) 58 CCC 323, Labor Code § 5412 defines the date of injury for continuous trauma claims as the date where the applicant knew (or reasonably should have known) that the injury was work related, and suffered disability as a result of the injury. This standard is easily

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manipulated by applicants and their lawyers, who can declare that they knew an injury was work related whenever it suits them, or declare total ignorance of the industrial nature of the problem until such time as they were informed by a physician of this fact.

Extensive case law tends to allow the defense to prove the requisite knowledge of the industrial nature of an injury only where a doctor can be shown to have informed the applicant. A leading case on this is *City of Fresno v. WCAB (Johnson)* (1985), 50 CCC 53. Thus, we will see this manipulated to prove a continuous trauma date of injury before April 19, 2004. Also, it will be very easy for applicants to allege small specific injuries that should really be considered part of the continuous trauma, or they may argue that there are multiple continuous trauma periods instead of just one. An expedited hearing should be sought by the defense when the applicant acts inappropriately here.

Will applicants be able to argue for an extension of TD even beyond the two years for any reason? It seems not, as the plain meaning of the statute would prohibit this. Nevertheless, it should be kept in mind that some headway has been made in the past by applicants under the former five year limitation. There was the 1986 case of *General Foundry v. WCAB* (51 CCC 375), where it was held that the jurisdiction of the WCAB could be extended in the case of an insidious and progressive occupational disease (asbestosis in that case). It seems tenuous to apply this reasoning to the new standard. Also, proving the "insidious and progressive" nature of the injury seems like quite a stretch for almost all cases routinely seen. A good counter-case is the recent *Finley v. WCAB* (2006) 71 CCC 361.

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06. Permanent Disability Redefined

A number of changes have been made to the concept of permanent disability.

A. Continuity of Payments

Labor Code § 4650(b) had provided that if injury caused permanent disability, the first payment was to be made within fourteen days after the last payment of temporary disability indemnity. It was provided that where the standard of permanent disability could not be determined at the date of the last payment of temporary disability, the employer nevertheless should commence the timely payment required of permanent disability.

New language has been added here to reinforce the requirement of continuous payments without a break. It is indicated that "When the last payment of temporary disability indemnity has been made pursuant to subdivision (c) of § 4656, and regardless of whether the extent of permanent disability can be determined at that date, the employer nevertheless shall commence the timely payment required . . .". Payment is still to be made based upon a reasonable estimate of the amount due at the end of the period for the payment of temporary disability, regardless of whether the permanent disability can be precisely defined.

This has caused a great deal of trouble. There appears to be no more "PD delays". Often adjusters receive notice that the applicant is permanent and stationary, but no work restrictions or impairment is offered. It seems that under this standard, at least a minimum permanent disability must be advanced unless the adjuster can justify a determination that there is no permanent disability.

B. Permanent Disability Redefined

According to Labor Code § 4600(a), permanent disability had been determined based upon the nature of the physical injury or disfigurement, the occupation of the injured employee, his or her age at the time of the injury, and the employee's diminished ability to compete in an open labor market.

This has been changed. No longer is permanent disability based upon an assessment of the applicant's loss of ability to compete in an open labor market. The new standard for permanent disability is what the applicant's lost future earning capacity is as a result of the injury. What this exactly means is unfortunately still unclear, and is the subject of continued speculation.

Furthermore, the "nature of the physical injury or disfigurement" is now to incorporate descriptions and measurements of physical impairments and corresponding percentages of impairments that have already been published in the American Medical Association's Guide to

the Evaluation of Permanent Impairment, Fifth Edition (AMA Guides). This is a tremendous change, and represents an attempt to rein in the perceived variation in permanent disability ratings for cases with the same objective findings. While (as discussed below) the new permanent disability rating schedule has been the subject of emphatic controversy, the objectification of permanent disability has been less controversial. There has been some grumbling that the objective standards of the AMA Guides are illusory, and that they were never meant to serve as the basis for solving litigated disputes. However, a change was needed, and that seems to be generally accepted.

The days of speculative work restrictions being described by doctors and interpreted by raters in order to serve as the basis of permanent disability assessment are rapidly disappearing. Now, the AMA Guides are used with tremendous detail, and what is objective about diagnostics and the physical examination serve as the basis for an impairment rating. Each and every body part has a chapter, and a method for determining impairment based on objective evidence and the physical exam. There is a chapter on pain, and chapters on general use. A great deal of discretion has been taken out of the hands of examining physicians.

The process is just beginning, but there are almost endless possible issues presented by the existence of this very thick book, the AMA Guides. Applicant's attorneys are scouring the AMA Guides to find ways to attack its use when it suits their purposes. There will no doubt be litigation on a variety of issues for decades to come. It has even been proposed that the AMA Guides themselves allow a physician to go outside the bounds of the Guides where appropriate.

Using the AMA Guides will likely become an area of specialized expertise. Although classes and seminars are everywhere, this can often be a case of a little knowledge being a bad thing. In a national study done by Bringham and Associates, 80% of all ratings were incorrect; 89% of those were too low. In the experience of many practitioners, most of the ratings done by physicians in their own reports are wrong.

Work restrictions are still needed for return to work considerations, as well as implementation of vocational rehabilitation or the voucher. Work restrictions are needed in medical reports and are consistently being provided. However, disability is no longer about work restrictions. It is about impairment, measured by a consistent standard as objectively as possible.

The New Permanent Disability Schedule

Under the new Labor Code § 4660(b)(2), the Administrative Director was mandated to produce a new schedule for rating permanent disabilities. This happened, and a plethora of Regulations were modified in order to produce it. The new rating schedule is now in common use.

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This has perhaps been the single most controversial part of SB 899 since it began. The strong perception has been that the new rating schedule produces a disability far below what was previously allowed. As described in the prologue to this booklet, studies have been done and allegations made regarding the alleged unfairness of this schedule. The complaint is that it was the intention of SB 899 to objectify permanent disability, but not reduce it dramatically across the board. Interestingly, the anger and controversy centers primarily not on the statutory changes in the law, but rather the schedule itself, which is an administrative creation. Andrea Hoch, the Administrative Director who created and published the schedule, was charged with abusing her discretion and disregarding directives given by the statutes.

This schedule is intended to produce a percentage measure of the applicant's diminished future earning capacity. It begins with the impairment as dictated by the AMA Guides, and then adjusts that number three times, to produce a final permanent disability percentage. Adjustments are made for age, occupation, and – a whole new category is created here – future earning capacity loss. This last adjustment exists in recognition of the fact that the AMA Guides do not consider the impact on work when assessing impairment. Thus, there needs to be an upward adjustment in order to compensate.

Most practitioners are aware of the string of numbers characterizing a typical rating. The new system is not so different. There is a new way of characterizing body parts and producing a stating number on the string, and of course there is now a third adjustment. There is an entirely new way of calculating psychiatric impairment; now the Global Assessment of Functioning (GAF) score is used as the basis for this. The multiple disability table has been replaced with a combined values chart. Value decisions are made by the schedule on the subject of pain and resulting impairment. The use of this schedule is just beginning, and we certainly will see issue after issue raised about its use in the future.

According to Labor Code § 4660, the Administrative Director was to create the new permanent disability schedule based upon the Evaluation of California's Permanent Disability Rating Schedule Interim Report. This was published in 2003 by the Rand Institute. She was also to rely on "data from additional empirical studies". The accusation has been made that this was not done, and a wide campaign has been mounted challenging the legitimacy of this schedule. That includes media attacks, legislative sessions and proposals, and challenges in the courts. The Office of Administrative Law (whose approval was required) put out a memo supporting the enactment of the emergency Regulations that created the schedule. It was pointed out that the legislature mandated its issuance, and that the Administrative Director had used "all available relevant information".

Thus far, the schedule has survived, but it remains under attack in all three areas. Andrea Hoch, in seeking confirmation as Administrative Director, was a target. She was confirmed, but in that process assurances were made that the schedule would be looked at and possibly revised. The current acting Administrative Director, Carrie Nevans, has stated that sufficient empirical data about the issue of whether the new schedule indeed has unfairly reduced permanent

disability benefits will be available, and the earnings capacity adjustment numbers will be reviewed, only after July of 2006. Civil court challenges have failed, and the issue has been brought at the WCJ level; it is just a matter of time before this is reviewed. Legislative efforts continue. It may be that at least a revision of this schedule is inevitable.

Application of the New Schedule

Given the allegedly low numbers, the application of the new schedule has been a huge issue in every day practice. Labor Code § 4660(d) sets the standard for this. It states that:

> The schedule . . . shall apply prospectively and shall apply to and govern only those permanent disabilities that result from compensable injuries received or occurring on and after the effective date of the adoption of the schedule . . . For compensable claims arising before January 1, 2005, the schedule as revised . . . shall apply . . . when there has been either no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability, or when the employer is not required to provide the notice required by § 4061 to the injured worker.

The schedule was published before January 1, 2005. In the eyes of at least one local Judge, this language means that the new schedule does not apply to those cases with dates of injury before 2005 (*Aldi v. Carr* (2006) case number SFO 0485703). We do not agree, and in our experience, neither does most of the community. The statute sets out that the new schedule applies to all dates of injury. However, a case may still fall into the old schedule if one of three exceptions are met. The DWC published a clarification letter in August of 2005 that supports this idea.

1. There is a "comprehensive medical-legal report" done in the case before 1/1/05 that indicates the existence of permanent disability.

2. There is a treating physician's report done before 1/1/05 that indicates the existence of permanent disability.

3. The defense before 1/1/05 is required to provide the applicant with notice under Labor Code § 4061. That section provides that "together with the last payment of temporary disability" the applicant is to be sent a notice. Therefore, the question is whether the last payment of temporary disability was made before 1/1/05.

There is the possibility that any comprehensive medical-legal report done before 1/1/05 will suffice to invoke the old schedule. The language is awkward here: "there has been either no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability". Does the requirement of a finding of permanent disability apply to both treating reports and QMEs, or just the treating doctor reports? The defense should take the former position.

The statutory scheme arguably contemplates application of the old schedule where there some idea of permanent impairment or at least P&S status before 1/1/05. There is also the question of what constitutes a report that indicates the existence of permanent disability. Does this indication have to explicit, or will evidence of serious pathology such that no reasonable person could envision zero permanent disability be sufficient?

We will no doubt be seeing cases on all of this in short order. In the meantime, we are left with a variety of issues. What exactly constitutes the "last payment of temporary disability"? What does it mean that a medical report, whether medical-legal or treating in nature, be "has been"? Sometimes reports are not received until well after the exam. Sometimes reports are not written, and decisions regarding the case are not made by a doctor, until well after the exam. In the writ denied case of *Biller v. WCAB* (2006) 71 CCC 513, a report was written before 1/1/05, but was signed and served after that date. The new schedule was used in this case.

Applicant's attorneys and physicians have almost universally tried a tactic that has not been accepted by the defense, and in our experience, by the Judges. A series of reports issued in December 2004 in almost every case that was still the subject of temporary disability. The report would attempt to make a finding of permanent disability even without a permanent and stationary status. The report would state that there was indeed permanent disability, or that it was certain that permanent disability would exist. There is not citable case law on this yet, but in *Daniel Vera v. Sapper Construction* (case number SDO 0318989), the Board not only supported a multiple level analysis of when the new schedule applies, but also specifically refused to recognize a treating doctor's report which used just this tactic.

Getting Away from the Schedule

Applicant's attorneys have proposed ways to get around the use of the schedule if it is accepted as legitimate. It should be said first, though, that they may not always want to. Despite the hue and cry over the relative impact of the schedule, at one convention the audience was advised to accept use of the new schedule in heart and psychiatric cases. In some cases, the new schedule can indeed produce higher permanent disability ratings than the old.

The main strategy proposed here is to introduce evidence extrinsic to the rating schedule. The argument runs that the schedule may not in every case fairly demonstrate the actual permanent disability as newly defined, i.e., the applicant's loss of earning capacity. There is some precedent for this. Labor Code § 4660(c) allows for the schedule to serve as "prima facie evidence of the percentage of permanent disability". This language did pre-exist SB 899.

On the other hand, Labor Code § 4660(b) states that ". . . an employee's diminished future earning capacity **shall be** a numeric formula . . ." (emphasis added) and goes on to describe the schedule from there. This language seems to require that the earnings capacity be

defined by the schedule. This language did not exist prior to SB 899, and therefore any prior case law on the point may not be effective any longer.

Assuming that this statutory burden is overcome, applicant's attorneys will rely on cases such as the well-known and often used *LeBoeuf v. WCAB* (1983) 48 CCC 587. In that case, a finding of permanent disability was set aside because the applicant's inability to complete vocational rehabilitation had not been considered. In accordance with this thinking, the schedule is certainly only a prima facie showing of permanent disability. In fact, in *LeBoeuf*, the Court emphasized that the applicant's vocational retraining was an important factor that should be known before permanent disability could be properly assessed, because it certainly could affect his ability to compete in the open labor market. The definition of permanent disability has changed. Absent statutory prohibition, however, the logic arguably remains the same. Post SB 899 there is one writ denied case where this kind of evidence was allowed. This is *County of Los Angeles v. WCAB (Harun)* (2005) 70 CCC 1339.

Applicant's attorneys have visualized a system wherein a vocational expert is called in every case, preferably testifying by way of written report. In this version of reality, which does seem to exist in some other jurisdictions that use the AMA Guides, the parties agree on a vocational expert just as they would on an AME. The expert compares the disability with the applicant's former job duties, experience, education, and other relevant factors, in light of the impairment as described by medical experts. Preferably some scientific data is used. He or she then produces an opinion regarding the percentage loss of earning capacity suffered by the applicant. It is argued that the schedule does not accurately reflect the applicant's loss based on this extrinsic evidence.

Applicant's attorneys are serious about this, and have put on witnesses of this sort in selected cases. One local Judge has allowed the extrinsic evidence in, and made a finding in excess of the schedule. Naturally, the defense has shown little tolerance for this. One problem which may be helping to deter these sorts of actions is: who is going to pay for the expert? This is not medical-legal evidence. The applicant's attorneys are looking at Labor Code § 5811, and are hopeful this will be considered a justifiable cost. However, they may have to front the expense in these sorts of cases.

It has been pointed out that the age adjustment in the schedule remains the same. Since the definition of permanent disability has changed from loss of ability to compete in the open labor market to a loss of earning capacity, arguably the age adjustment should have changed completely. Being young reduces the permanent disability per the schedule. However, while being young was an advantage in terms of ability to compete, it may provide for a greater loss of earning capacity because there is much more time to work. Also, the occupational variant has been called into question given this change of definition, with arguments along the same lines.

C. Increase in Permanent Disability for Serious Injuries

Labor Code § 4658 lays out the number of weeks of permanent disability which are to be paid depending on the percentage of permanent disability. New subsection (d)(1) sets forward a new standard here. This Labor Code applies to injuries on or after January 1, 2005.

For those injuries which result in permanent disability of 70% to 99.75% (life pension cases), the number of weeks for which permanent disability is paid is raised to sixteen. This is a dramatic increase from prior allowances.

D. Permanent Disability Benefits Modified for Return to Work

Labor Code §§ 4658(d)(2) and 4658(d)(3) contain a new incentive program to return injured workers to their job, or to a modified or alternate position. Changes were made by SB 899 in regards to the return to work program attempted in earlier reforms. Revisions of Labor Code §§ 62.5 and 139.48 essentially gave up on those former programs. There are also in the works proposed Regulations, numbered 10001 through 10003, which clarify certain aspects of the new program and provide forms to be used. At this writing, those Regulations are in their third draft form, and have not yet been adopted. The practitioner will have to be aware when they are adopted, as a failure to use the required forms may invalidate any offer by the employer to return to work.

Labor Code § 4658(d)(2) specifies that the applicant may receive an increase in permanent disability if he or she is not offered the former regular job, or modified or alternative work. Subsection (d)(3) also decreases permanent disability if the offer is made. The increase applies if the employer has at least fifty employees. The decrease applies regardless of the size of the company. This is not such a good deal for the applicants.

The employer's offer of modified or alternative work is only valid under certain conditions. The offer of work must be for at least a 12-month duration. It must be work within a reasonable commuting distance, the pay must be at least 85% of what it was for the regular position, and the work must be within the applicant's capabilities. If the applicant is a seasonal worker, proposed Regulation § 10002(g) provides for work to be offered within a year, under reasonably similar conditions.

Further guidance is given by § 4658.1, subsections (d), (e) and (f). Subsection (d) specifies that increasing working hours does not count for purposes of specifying comparative wages. Subsection (e) specifies that when determining the actual wages and compensation, the minimums and maximums for purposes of permanent disability are not considered. Subsection (f) indicates that the reasonable distance of the employee's residence may be waived by the employee, that any objection is deemed waived if the employee accepts the work and does not object to the location within 20 days of being informed of the right to object; and finally, if the

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offered work is at the same location and the same shift as the employment at the time of injury, it is conclusively deemed to be a non-issue.

If the offer is not made, the applicant is entitled to a 15% increase in the payments of permanent disability. Note that this is not a 15% increase to permanent disability in general. Rather, it is a 15% add-on to each check sent to the applicant for permanent disability following the close of the 60-day period. On the other hand, if within the same 60 days the employer does offer the applicant regular, modified or alternative work, each permanent disability payment made after the date of the offer is decreased by 15%. If the applicant is terminated by the employer before the end of the permanent disability payout, the decrease is eliminated and payments are further increased by 15%. If the applicant voluntarily terminates employment, he or she does not get the increase, and the decrease stays in place.

Problems in Application

The offer must be made within sixty (60) days of permanent and stationary status. This can be burdensome to adjusters, who sometimes struggle to obtain work restrictions from physicians who issue PR-2 reports mentioning only that P&S status has been achieved. Note that the statute provides for both the increase and decrease contingent only upon the offer, and not the return to work. If the applicant returns to work within sixty days from the P&S status, it is reasonable to assume that an offer was made and accepted, even if there is no documentation to that effect. However, one could envision a situation where the offer was not made on time, and the injured worker returned to work after the sixty day period expired. In that case, applicant attorneys will argue that there must be a 15% increase, and of course no decrease.

Further, this could get a bit tricky as the permanent and stationary status is an issue of medical fact, and one often in contention. One could envision multiple problematic scenarios here. One possibility: an offer could be made in good faith, following the issuance of a P&S report by a treating doctor. Later a QME could reveal that the P&S date was considerably earlier. On the face of it, a 30% difference in permanent disability could arise as a result.

Proposed Regulation § 10002(c) discusses the situation where the claims adjuster relies on a report for P&S status, and an offer is made. Later a dispute arises as to the actual P&S date. In that event, the adjuster may enforce the 15% decrease until there is a final adjudication of the issue. If the applicant proves a later P&S date, he or she is reimbursed until another offer is made. Also, if the defense wins the issue, the applicant gets reimbursed up until the date the determination is made. There doesn't seem to be much of a point to withholding the money under this scheme, except for the period between the determination and the new offer. Of course, if the applicant wins the issue, most often there will be back owed temporary disability for that period anyway.

When does the adjusted payment begin? According to subsection (d)(2)the increase only begins after the 60 days has passed to make the offer of work. So only the remaining payments

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need be adjusted. The employer therefore has some time without penalty to analyze the matter and make a decision. A decrease goes into affect according to subsection (d)(3) "from the date the offer was made".

This structure is disparate from other areas of the law. The provisions in the 2003 legislation respecting modified or alternative work in the "voucher" system had provided for an offer to be made to the applicant at the end of temporary disability payments - not the permanent and stationary status as specified in these statutes. Employment and labor law requirements of course permeate the process at every stage, but the requirements of permanent accommodation apply as of the date the work restrictions are assessed and communicated. This is made even more interesting by the new Labor Code § 4658.1. This defines regular work, modified work and alternative work, and lays out the conditions under which these terms may be properly utilized for purposes of employing an increase or decrease in permanent disability as noted herein.

There seems to be general agreement that this new standard applies only to dates of injury on or after January 1, 2005. The proposed Regulations use that date. However, this consideration is subject to the extremely confusing Labor Code § 4658(d)(4). That indicates that "the schedule provided in this subdivision" is to take effect for all injuries on or after April 30, 2004. It also provides that injuries before that date also are subject to this "schedule", if one of the three exceptions outlined in Labor Code § 4660 is met. It is very confusing as to what this refers. It may refer to the number of weeks specified in subsection (d)(1), but that subsection explicitly refers only to dates of injury on or after 1/1/05. If it is intended to speak to the return to work program, arguably the 15% increase/decrease could have an earlier date of application.

It is important to be aware that applicant's attorneys are making quite a bit of noise about the obligations of the employer under the Fair Employment and Housing Administration (FEHA) and Federal requirements as well. Discrimination against a disabled person can subject an employer to suit. With the subtraction of vocational rehabilitation from the system, this issue has been pushed to the forefront. Although the obligations of the employer to reasonably accommodate such workers has been around for a long time, the removal of vocational rehabilitation has given employees more incentive to engineer cases so that they can return to work.

Note that the insurance adjuster has to work with the insured to provide any offer of return to work. This can become complex and difficult because of the employer's independent obligations in this area. The obligation of the employer is complex and burdensome. Meeting the requirements of this return to work program is not sufficient to discharge those obligations.

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07. Apportionment

Traditionally, apportionment of permanent disability was only allowed within specific parameters. These parameters were judged by some to be rather strict. Certainly, an attempt at a finding of apportionment would meet with specific challenges. In addition, the maxim that apportionment applies to disability, and not to causation, was a long-standing principle of workers' compensation law. All this was radically changed by SB 899.

There were previously three Labor Code sections which defined apportionment. Labor Code § 4750 provided for apportionment to disability which existed at the time of the industrial injury that was the result of a prior injury that the applicant had suffered. Labor Code § 4750.5 provided for apportionment to a subsequent incident of injury which created a definable disability. Labor Code § 4663, arguably the most difficult of the three, provided that apportionment could result from a non-industrial progressive disease. All of this has been completely repealed.

In its place are now two statutes only, which completely redefine what apportionment is. Labor Code §§ 4663 and 4664 give us an entirely new scheme. Apportionment of disability is now to be based on causation, and the employer is only liable for that portion of the permanent disability that is judged industrial. This has been and continues to be a tremendous boon to the defense.

Applicability of the New Standard

Apportionment has been the one area of the reform that has produced more case law than any other. No new Regulations have been enacted to support the statutes. However, the case law has been extensive and informative. In addition to telling us what the statutes on apportionment actually mean, they have helped along the way to define under what circumstances all of the provisions of SB 899 apply.

Pursuant to SB 899 § 47, it would appear from the face of these new statutes that they would apply to all dates of injury as of Monday, April 19, 2004, as long as such application is prospective; that is, it does not follow an "existing order, decision or award". What exactly does that mean?

The first attempt to set a standard did not last. This was the case of *Scheftnerv. Rio Linda School District* (2004) 69 CCC 1281. In *Scheftner*, the WCAB issued an *en banc* decision to help interpret the application of § 47,. The Board was confronted with a situation in which a case had been set for an MSC before SB 899 had passed. An order had issued closing discovery and submitting the case before the April 14 date. However, the Findings and Award has issued after the April 19 date. It was held that an "existing order, decision or award" included orders of

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closure of discovery at a mandatory settlement conference. Thus, the new standards of apportionment did not apply.

For a little time this looked like it was going to be the way it was, and a few lucky applicants had their cases decided under this standard. Examples are *City of Napa v. WCAB (Foster)* (2005) 70 CCC 890, and *SCIF v. WCAB (Rowe)* (2005) 70 CCC 906, and there were many other writ denied cases. However, multiple cases subsequently issued from the Appeals Courts which reversed this thinking. *Scheftner* itself was overturned on appeal later on – the cite is *Rio Linda Union School District v. WCAB (Scheftner)* (2005) 70 CCC 999.

Before this explicit reversal of the *Scheftner* case, the charge was lead by the case of *Kleeman v. WCAB* (2005) 70 CCC 133. This Appeals Court held that all aspects of the new apportionment statutes applied to all cases pending as of April 19, 2004. In *Kleeman*, the matter went to trial, and was submitted before SB 899 had passed. Before the Findings and Award issued, SB 899 was passed into law. The WCJ decided to reopen and develop the record in regards to the new apportionment standards. The court of appeal held that this was a valid decision, since there was no order or award before April 19, 2004.

Later, in the *Escobedo* case (discussed below) it was confirmed in an *en banc* decision that the Board must follow the direction of the Court of Appeals. Footnote 4 of *Escobedo* states that "*Kleeman* implicitly overruled the WCAB's *en banc* decision in *Scheftner* . . . " The Appeals Board, of course, must follow *Kleeman* under the principle of *stare decisis*.

Kleeman was also supported and even extended by the case of *Marsh v. WCAB (Bostitch)* (2005) 70 CCC 787. In *Marsh*, the case had already resolved by Stipulation and Award, and later became subject to a petition to reopen. In regards to that petition, the WCJ had already issued a Findings and Award following trial before SB 899 was enacted. The Award was challenged by a petition for reconsideration, and the WCJ decided to apply the new apportionment standards. He vacated the F&A in order to obtain medical evidence under the new standards of apportionment. The Appeals Court agreed with this course of action. The *Marsh* Court confirmed *Kleeman*'s dominance over *Scheftner*, as had *Escobedo* before it. It also allowed that the new apportionment standards apply to all pending cases, and that includes all cases except those ". . .where appeals have been exhausted and a decision is final or no longer pending." *Marsh* cited the *Green* case (described in the section of this booklet on penalties), which agreed with this point on the subject of penalty reform.

Support for *Marsh* and *Kleeman* by the Court of Appeals continued. The opinions of WCJs were set aside in favor of the new apportionment standards in *Beery v. WCAB* (2005) 70 CCC 1334, *Wilbur-Ellis v. WCAB (Flores)* (2005) 70 CCC 1096, *Richview v. WCAB (Gonzalez)* (2005) 70 CCC 1090, *Lindsay District Hospitals v. WCAB (Fuller)* (2005) 70 CCC 995, *Kresky v. WCAB* (2005) 70 CCC 1039, *Folsom v. WCAB* (2005) 70 CCC 1408, *Kenneth Vlach v. WCAB* (2005) 70 CCC 1052, *State of California v. WCAB (Kral)* (2005) 70 CCC 161, and *Aldworth Company/Keystone Freight v. WCAB (Lawrence)* (2006) 71 CCC 1. It was found that there was

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a final Award and that the appeals had been exhausted in the case of *Lawrence Hill v. WCAB* (2005) 70 CCC 1028; new apportionment was not allowed.

It became clear that the new standards would apply to all cases that are still pending at any stage. Also, as discussed herein, it was decided that all cases required medical evidence to explain their position on apportionment under the new standard. Case after case was taken off calendar as a result, even in the middle of trial proceedings or even afterwards, causing tremendous delays and putting some applicant attorneys in a disadvantageous financial position. Over two years later, we still see this happening quite often.

Apportionment and Petitions to Reopen

There also arose the issue of how to deal with petitions to reopen. The original award would be final and would no longer be "pending." Thus, it would not be disturbed by the new apportionment statutes; however, there remains the pending issue of a claim for increased disability.

In *Vargas v. Atascadero State Hospital* (2006) 71 CCC (further citation not yet available), such a case existed. An original award of 67 percent had already issued, and a petition to reopen had been filed. The petition included a claim for new body parts psyche and TMJ. The judge submitted the case and thereafter, before findings and award issued, SB 899 was passed. He reopened the record in order to obtain proper medical evidence on the issue of possible apportionment as to that portion of disability that had allegedly increased. The *en banc* court agreed that his action was proper.

In doing so, they were able to draw a lot of principles from the case law that had been enacted up to that point. They turned to *Marsh v. WCAB* (above) which had concerned apportionment of disability following a petition to reopen. *Vargas* concluded that the provisions of SB 899 do apply to the issue of increased permanent disability alleged in any petition to reopen, but that the new apportionment statutes could not be used to revisit or recalculate the level of permanent disability, including the presence or absence of apportionment, in the original order. Indeed the Board held that "applying the new apportionment provisions to the issue of increased permanent disability the issue must be determined without reference to how or if apportionment was determined in the original award." Apportionment of permanent disability is in dispute, but only that permanent disability that is allegedly over and above the original amount.

This is without a doubt a difficult standard in practice. It is hard enough to apportion to pathology without having to further divide it into that occurring before and after the original award date. At some point, the question of whether this can be done by a medical forensic without guesswork is going to become a serious concern.

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It should be noted that before *Vargas*, there was a writ denied case on this subject. In the case of *Hill v. WCAB* (2005) 70 CCC 1028, the parties had entered into a stipulation regarding permanent disability and apportionment. Later a petition to reopen was filed, and the WCJ applied the doctrine of *res judicata* to the issue of apportionment. It appears that in doing so he violated the requirement of *Vargas* that new and further disability be determined without regard to how apportionment was decided in the underlying award. It appears though that the Judge was relying on the *Scheftner* decision before it was reversed, so this case likely has little impact.

Labor Code § 4663 and *Escobedo*

The old Labor Code § 4663 has been replaced by a new one. This statute redefined the entire concept of apportionment – turning it on its head really – by making the astounding revision in subsection (a) that "Apportionment of permanent disability should be based on causation." Newly enacted Labor Code § 4664 states that "The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment."

So what constitutes a cause of disability? "Causation" is a tricky legal term, and its use in this context has been subject to severe debate. Following the passage of SB 899, no one case is more important to this area than the *en banc* decision of *Escobedo v. Marshall's; CNA Ins. Co.* (2005) 70 CCC 604. Here an applicant had problems with her knees as a result of an injury, but also had underlying arthritis. Both were found to be causes of her permanent disability. Under the old law the maxim was that we "apportion to disability, not causation", and in this scenario no apportionment would have been allowed. *Escobedo* held that the standard of causation was referring to what caused the disability, not the injury. It was also held that "other factors" beyond those previously allowed could serve as a valid basis for apportionment. Examples given included "pathology, asymptomatic prior conditions, and retroactive work restrictions". Accordingly, arthritis was found to be a proper source of apportionment in that case.

This confirms that the standard has completely changed. In fact the Court in *Escobedo* went out if its way to emphasize that by repealing the old statutory structure, the legislature had intended to make a major change in the law. The Court stated that "new viability" had now been conferred on an older case where apportionment was not to be found under the old standard, but would have been under the new. Specifically mentioned was *Baker v. IAC* (1966) 31 CCC 228; there, a person with a lung condition had been caused by both industrial and non-industrial factors (smoking and industrial asthma). Apportionment was applied, but the *Baker* case was later expressly disapproved by the Supreme Court. It seems that under the new standard the *Baker* analysis would be correct.

There is also an insidious Footnote 9 in this case. That footnote indicates an awareness that traditionally, if an industrial injury "lights up" – that is, aggravates or accelerates – a non industrial condition, and causes disability, the applicant's problem is indeed industrial in nature. Traditionally, apportionment was not allowed in this sort of scenario. This is a variation of the

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"eggshell plaintiff rule". *Escobedo* refused to comment on this scenario, stating that "In this case, however, there is no assertion that applicant's preexisting arthritis was exacerbated or accelerated by her industrial injury. Accordingly we need not and will not now address the continuing validity of these principles . . ." *Escobedo*'s facts, however, and the reference to the *Baker* case, imply that apportionment is likely to be applied even in this sort of scenario.

Applicant's attorneys have been unable to avoid apportionment so far under this footnote. In the case of *Mello v. WCAB*, (2005) 70 CCC 1525, apportionment was found. The doctor on whose opinion the finding was based stated that the applicant's non-industrial condition of scoliosis would not necessarily have become symptomatic absent the industrial injury. There have also been the cases of *Leung v. WCAB* (2006) 71 CCC 437 and *Madayag v. WCAB* (2006) 71 CCC 441, where apportionment was allowed to asymptomatic pre-existing degenerative disc disease.

Also of note is Footnote 7 of *Escobedo*. There it is pointed out that Labor Code § 5500.5 does not allow for apportionment to a prior industrial cumulative trauma which has gone uncompensated. Again, *Escobedo* makes no comment as the issue is not before it. However, it seems that the full impact of the new apportionment standards on Labor Code § 5500.5 may not yet be fully understood.

***Escobedo* and Medical Evidence**

Labor Code § 4663 goes on to state that any physician preparing a report must specifically address the issue of the causation of disability and apportionment "In order for a physician's report to be considered complete. . . " This was confirmed by the *Escobedo* case. The physician is to identify "what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment, and what approximate percentage of the permanent disability was caused by other factors, both before and subsequent to the industrial injury, including prior industrial injuries."

If a physician is unable to make an apportionment determination, he or she is to state specific reasons why he or she could not do it. The physician is then to consult with other physicians or refer the employee to another physician "from whom the employee is authorized to seek treatment or evaluation," in order to make his/her final determination.

Escobedo interpreted this to mean that a failure to address the issue of apportionment under the new standard rendered a medical report unsubstantial. An expose of the historic requirement that all medical reports must be substantial is recited in *Escobedo*; it is confirmed that the report in question cannot be relied upon by a WCJ if it is not substantial. Therefore, a failure to properly consider apportionment under the new standard renders any report useless as evidence. The Court said, ". . . if a physician opines that approximately 50% of an employee's back disability is caused by degenerative disc disease, the physician must explain the nature of

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the degenerative disc disease, how and why it is causing permanent disability at the time of the evaluation, and how and why it is responsible for approximately 50% of the disability."

In *Escobedo* it was found that the medical opinion in question was substantial. One is given to wonder if an effective attorney might not be able to demonstrate in many cases that the medical opinion in question is speculative. It is to be remembered that *Escobedo* confirmed that apportionment is the defense's burden of proof. On the other hand, the willingness of the *Escobedo* court to find the medical evidence substantial and its specific examples given in the case set forth an arguably liberal standard. Also, it is to remember that the statute only requires physicians to give an "approximate percentage".

In the reported case of *Wood v. SCIF*, 34 CWCR 15, the AME failed to specify "how and why" he arrived at a fifty-fifty split on the apportionment issue. Accordingly apportionment to degenerative changes was not allowed in this *en banc* decision. There have been other writ denied cases where the medical evidence was found to be insufficient. These include *California Water Service v. WCAB (Pizzurro)* (2006) 71 CCC 251 (physician fails to apportion any specific percentage of PD to non-industrial factors), and *City of Santa Clara v. WCAB* (2005) 70 CCC 1713 (apportionment to heart problems in orthopedic case found to speculative). In the case of *Coca Cola Bottling Co. v. WCAB (Saucedo)* (2006) 71 CCC 279, it was held that an AME's report had properly considered and denied possible apportionment.

Apportionment Standards and AOE/COE

Reyes v. Hart Plastering (2005) 70 CCC 223 is a significant panel decision. It appears that an enterprising defense attorney successfully attempted to argue that some of the principles outlined in the new Labor Code § 4663 and 4664 analysis should pertain to the question of industrial injury at trial. In *Reyes*, a preexisting non-industrial seizure condition caused a fall and a severe injury. The WCJ concluded that the principles enumerated under the new apportionment standards were applicable to the AOE/COE analysis. The WCJ was reversed, and it was held that the apportionment standards applied to proposed reduction of permanent disability, and not to the issue of causation of injury. This thinking was explicitly approved in the *Escobedo* decision.

Disclosure under § 4663

Under Labor Code § 4663, an applicant is mandated where requested to disclose all previous permanent disabilities and physical limitations. This seems to result in a new rule for discovery in workers' compensation, and there appears to be no reason why the defense would not routinely make this demand.

The Apportionment Loophole

Labor Code § 4664(b) closes a classic "apportionment loophole." This "loophole" applied to situations where a Findings and Award or Stipulation was made regarding permanent disability in the past, but which was subject to the applicant's argument that he or she had recovered from that permanent disability, and thus apportionment should not apply. This argument often worked in litigation up until this point.

However, this new subsection indicates that a prior award of permanent disability is conclusively presumed to be just that - permanent disability. In that event it is "conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury."

Labor Code § 4664(c) chimes in along these lines and states that applicants may not accumulate, over one lifetime, permanent disability awards on the same body part and exceed 100%. An exception applies if the applicant's injury or illness is conclusively presumed to be total in character, pursuant to § 4662. Specific regions of the body are listed in Labor Code § 4664(c), even beyond those of the statute it references, including: a) Hearing; b) Vision; c) Mental and behavioral disorders; d) The spine; e) The upper extremities, including the shoulders; f) The lower extremities, including the hip joints; g) The head, face, cardiovascular system, respiratory system, and all other systems or regions of the body not listed in subparagraphs a to f inclusive. This obviously is every part of the body, and it is wondered why the Legislature bothered to list them specifically.

Subsection (c)(2) states that "Nothing in this section shall be construed to permit the permanent disability rating for each individual injury sustained by an employee arising from the same industrial accident, when added together, from exceeding 100%."

The *Fuentes* Rule Reconsidered:

One area of severe debate resulting from this new apportionment scheme has been the *Fuentes* Rule. In *Fuentes v. WCAB* (1976) 41 CCC 42 the court had considered under the previous statutory scheme the proper method for arriving at the appropriate percentage of permanent disability, and its monetary value after applying apportionment. In the workers' compensation system, the higher the permanent disability is, the more weeks of permanent disability are paid out, and the more the permanent disability is worth. *Fuentes* considered three separate possibilities for the payout of permanent disability where apportionment applied. The choice would make a huge difference to the parties.

The first possible method (A) would be to simply subtract the amount of apportioned permanent disability from the total and then pay out based on the resulting percentage. So a 50 percent permanent disability with 50 percent apportionment would result in a 25 percent

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permanent disability total. The applicant would be paid out the number of weeks allowed for 25% permanent disability. The second method (B) would be to first determine the number of weeks allowable under the permanent disability itself before apportionment, and then multiply that number of weeks by the percentage of industrially related disability after apportionment. The third possibility (C) would be to consider the total amount of money that would be owed if there were no apportionment and then subtract only the money the applicant would be due given the prior disability. Obviously, the applicants wanted choice C and the defense wanted choice A.

Fuentes adopted formula A, and that decision by the Supreme Court of California has substantially reduced the payments the defense must make when apportionment is applied. This has been the rule of law consistently over the last three decades. However, there is no question that the complete repeal of the statutory apportionment scheme is replaced by an entirely new set of standards. The question is whether the rationale of *Fuentes* should be followed and applied under the new statutory scheme. If *Fuentes* does not survive the change in the law, the resulting increased payouts could seriously offset much of the permanent disability savings engineered by SB 899.

For now it appears that *Fuentes* is in serious trouble. In the case of *Nabors v. WCAB* (2005) 70 CCC 856, an *en banc* decision, a majority of the Board upheld the application of *Fuentes* to the new statutory scheme. However, *Nabors* was recently (days ago at this writing) reversed by the Court of Appeal. There is no doubt it will be appealed to the California Supreme Court. At this writing, there are many other cases in this area that are scheduled to be heard by the Court of Appeals, so the fight is far from over.

In an extensive decision, the WCAB in *Nabors* did carefully consider the reasoning the California Supreme Court used when it decided to use the third option. *Fuentes* made strong reference to the prior Labor Code § 4750 and also strongly considered that employers would be more inclined to hire persons with prior disability should they not face higher expenses than they otherwise would in the event of an industrial injury. The idea it seems was to give the prospective employer the assurance that it would not have to pay for the prior disability if there were a new accident. The WCAB thought this reasoning still applied. In *Nabors* the applicant was determined to have a permanent disability rating of 80 percent. There had been a prior findings and award of 49 percent. Both injuries had taken place with the same employer, although there was coverage by different carriers. The judge issued instructions that resulted in a new award of 31 percent only. The WCAB upheld this decision.

In reversing the WCAB, the Court looked closely at *E & J Gallo Winery v. WCAB (Dykes)* (2005) 70 CCC 1644. *Dykes* was confronted with the same sort of scenario. The applicant had injured his back in 1996 while employed as a winery worker; there was a stipulated award of 20.5% permanent disability. He had a subsequent injury while working for the same self-insured employer that resulted in a finding of 73 percent disability to the back. Rather than reduce the PD percentage in accordance with *Fuentes*, the judge subtracted the prior amount of money paid to the applicant from 1996 back injury - $11,680.00. Gallo appealed, indicating that

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under *Nabors* and *Fuentes* it was the prior percentage of disability and not the dollar amount that should be subtracted. The court found against Gallo. When the Court of Appeal looked at the *en banc* decision in *Nabors*, it concluded that the same rationale should apply. The fact that the employer was insured by different carriers did not make a difference.

It is important to note that *Dykes* limited its holding to "where an employee sustains multiple disabling injuries while working for the same self-insured employer". It was explained that in this context "we see no reason to treat an employee who has been injured twice differently from a similarly situated employee who was injured once with the same level of disability." However, it is essential to realize how limited in scope this case really is. Likewise, *Nabors* was careful to exercise the same judicial restraint. At this writing, there is no law on the applicability of *Fuentes* to cases where there are different employers, or where there is apportionment to pathology rather than specific pre-existing injuries that have resulted in a prior Award.

The new apportionment standards applied right away, and this has had a huge impact on the value of cases. Apportionment now applies to many more cases than it had, and together with the *Fuentes* rule, has hit the monetary value of permanent disability hard across the board. If this rule does not survive, it will go a long way toward restoring that lost equity. One merely need to consider a case wherein an injured worker is totally permanent disabled (100%), but it is found that there is a minimal amount of apportionment. Paying out an award at 99% permanent disability is tremendously less expensive than paying out permanent disability at the temporary disability rate for life.

Under *Nabors* and *Dykes*, one wonders how apportionment will be accounted for when PD is paid out. Will the money be subtracted from the far end of the Award? Typically this is what happens with applicant attorney's fees in order to avoid reducing the weekly amount the applicant receives. However, money paid later is of less value, so this could constitute a taking from the defense. Will the deduction be spread out over payments made? This may be undesirable given the possibility of accounting errors and penalties.

Another open question is what impact all of this might have on the doctrine under *Wilkinson v. WCAB* (1977) 42 CCC 406. That case and its progeny set the standard for the convergence of permanent disability when it resulted from more than one injury. *Wilkinson* was decided immediately after *Fuentes*, and like *Fuentes*, was premised in part upon the now repealed Labor Code section 4750. Applicant's attorneys will no doubt argue that under the new apportionment statutes, all injuries to the same body parts converge for purposes of determining permanent disability regardless of the circumstances. This would drive PD up. The defense will argue that no convergence at all is allowed, and that each injury must be considered on its own merits. This is likely to get very complicated when permanent disability under the old and new schedule is compared. Thus far, we have one writ denied case which holds that the rule under *Wilkinson* has not changed. This is *City of Santa Clara v. WCAB* (2005) 70 CCC 1713.

Overlap

The requirements of both Labor Code §§ 4663 and 4644 run squarely into the issue of overlap. Overlap is part of a long history of this area of the law, and had to be dealt with. The appeals board in twin *en banc* decisions attempted to lay out the philosophy of overlap that will follow SB899, and to provide specific guidance as to implementation of its enunciated principles. The two cases are *Strong v. City and County of San Francisco* (2005) 70 CCC 1460 and *Sanchez v. County of Los Angeles* (2005) 70 CCC 1440.

The two cases are nearly identical, and for the most part lay out identical principles. *Sanchez* takes the time to lay out a detailed definition and history of the concept of overlap. It is appropriate to briefly review some of this here, as this concept is not always well understood. Overlap exists where permanent disability resulting from a new injury includes factors of disability that are the same as ones that already existed as a result of a prior injury or condition. So for example, a no heavy work restriction to the neck would overlap with a later restriction against light work to the neck. Sometimes the body parts for the prior and later injury are the same, and the work restrictions described for the respective injuries are to one extent or another the same. In that event, to the extent the work restrictions were the same they would overlap and the defense would not be made to pay twice for the same work restriction.

Sometimes the body parts are different. In that case, sometimes overlap applies and sometimes it does not. The key in the inquiry is not the parts of the body involved as much as whether the work restrictions are the same or not. As *Sanchez* describes "thus, the fact that the pre-existing disability and the new disability involved two different anatomical parts of the body while relevant did not in itself preclude apportionment using the rules of overlap."

Specific cases and fact patterns were cited. In *Mercier v. WCAB* (1976) 41 CCC 205, an applicant had a prior back disability precluding heavy lifting and repetitive bending, and then sustained a new industrial injury to his heart resulting in a limitation between light work and semi-sedentary work as well as restrictions against strenuous activities and severe emotional stress. It was held there that all the factors of disability attributable to the back were included and/or subsumed by the factors attributable to the heart injury, resulting in total overlap, and no new money for the applicant. In *State Compensation Insurance Fund v. IAC (Hutchinson)* (1963) 28 CCC 20, an applicant had a prior neck disability consisting of a constant pain becoming slight with overhead work and climbing and becoming moderate with lifting over 30 pounds. He sustained a new injury to his low back resulting in a disability consisting of minimal pain increasing to slight pain on heavy work. It was held that the disability from the neck injury overlapped the disability from the back injury because the latter resulted in pain when performing certain work activities. In *Edison v. IAC* (1928) 15 IAC 193, an applicant had previously lost 30/50s of the sight of each eye. He then sustained a new injury resulting in additional 17/50s loss of sight of his left eye. It was held that the applicant was entitled to compensation only for the increase in impairment. In *Gardner v. IAC* (1938) 3 CCC 143, an applicant had a prior left ankle disability resulting in partial stiffness from the ankle joint. Later

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he sustained a new industrial injury resulting in amputation of the left leg between the knee and hip joint. It was held that the rating for the loss of the leg was properly reduced by the rating for the ankle.

The difference between the *Sanchez* case and the *Strong* case was simply that of whether the body parts in question were the same or different. In *Sanchez,* the applicant sustained an injury to the left foot on December 18, 2002, and the parties stipulated that the left foot injury resulted in permanent disability of 7 percent. This was based on an AME report that found that the applicant had subjective disability including intermittent slight left foot pain becoming moderate with cold weather and rain. Previously, the applicant had received a 22 percent permanent disability award for a 1997 bilateral knee injury. This was based upon a loss of pre-injury capacity for kneeling, squatting, climbing, heavy lifting, pushing and pulling as determined by another AME. The *Sanchez* case was judged to be one with the same body parts but differing descriptions of disability for the respective injuries. There was no overlap.

In *Strong*, the applicant had multiple injuries. The most recent injury was to the low back and involved 70 percent permanent disability for a semi-sedentary restriction. Prior to that there were a number of awards, the most of which involved the left shoulder, left knee, left ankle and right wrist, but not the low back. There was a restriction limitation to light work which after apportionment from prior injuries was 42 percent and ultimately rated to a 60 percent. Overlap was found in that case, despite the fact that there were different body parts, because the work restrictions overlapped.

In considering the matter, the Board was careful to justify the continued existence of the concept of overlap. Although they acknowledged that Labor Code § 4750 no longer existed, they went in depth to describe how the concept of overlap was not only consistent but mandated by the new Labor Code §§ 4663 and 4664. It was also pointed out how the concept of overlap had not been explicitly excluded by the legislature in enacting SB 899. It was held that under 4663 overlap would apply as it always has without any substantial change.

However, Labor Code § 4664(b) required a fuller analysis. Recall that provision calls for a conclusive presumption of permanent disability where there is a prior award. *Sanchez* and *Strong* analyzed the language of that statute in light of overlap principles, and decided that the mandate that the "prior permanent disability exists" is not necessarily a mandate for apportionment in every case. Rather it remained to be determined if that prior disability overlapped with the new. If not, apportionment would not be proper. A specific process was laid out for performance of this analysis.

1. To invoke Labor Code § 4664(b), it is the defendant who has the burden of proving that there was a prior award. Actually, that is not always easy, as the award itself is not always available. These cases explicitly refuse to speak to what evidence may be used to prove this point in the absence of the actual award, other than to state that extrinsic evidence is allowed where appropriate.

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2. When the disability award is produced by the defense, it is conclusively presumed that the permanent disability it shows does exist. The applicant is not permitted under the new Labor Code § 4663 to show medical rehabilitation from the disabling effects of earlier injuries.

3. Once the defense has established the existence of the prior award, apportionment is appropriate. However, the applicant can avoid apportionment if it can be shown that the prior disability does not overlap the new. It is the applicant's burden to show that this overlap does not exist.

4. Any one body region cannot exceed 100 percent in permanent disabilities. This is in accordance with the statutory requirement and makes sense in light of the overlap principles outlined here.

In both *Sanchez* and *Strong*, the court upheld the findings of the lower court. In *Sanchez,* since the work restrictions in the subsequent injury did not match the 7 percent permanent disability, there was no overlap and therefore no apportionment. In *Strong,* there was almost a total overlap. Although the body parts were different, the work restrictions were the same type.

I note that the Board proceeds on the concept that percentages of permanent disability will be subtracted. To some extent the Board's findings here are subject to review, especially given the situation with the *Nabors* case as described above. We will have to await review of all these cases.

Note too, that overlap here is discussed only in terms of work restrictions. The Board acknowledges that overlap problems are going to exist when permanent disability is expressed under the AMA Guides. However as the problem was not before it in these cases, the issue was deferred. We will certainly be seeing more on this point in the future.

Is a C&R an "Award"?

There was never any doubt that a Findings and Award after trial or an Award following a stipulation of the parties would constitute an "award of permanent disability" under Labor Code § 4644(b). In an *en banc* decision, the WCAB spoke to the issue of whether or not a Compromise and Release could also be considered an Award. This is *Eric Pasquotto v. Haywood Lumber* (2006) WCAB No. GRO 0028123, 02/27/2006.

This decision does give a bit of a mixed message. It does confirm that a Compromise and Release Agreement approved by the Workers' Compensation Appeals Board (C&R) does generally constitute a court award. After all it awards benefits the same as a Finding and Award or a Stipulated Award. However, it is also indicated that an approved C&R agreement is not

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necessarily a court “award of permanent disability”, even if the C&R resolved the issue of permanent disability. In fact, it turns out that in most cases it is not.

In *Pasquotto,* there was only one medical report on which the case settled. Nevertheless the court held that it would be "entirely speculative" for them to draw the conclusion that the parties intended that report to speak to the actual level of permanent disability, and mandate apportionment under Labor Code § 4644(b). The Board does an excellent job here of describing why the face of a C&R even with limited medical reports supporting it cannot be used as a basis for concluding what permanent disability was warranted. It is pointed out that the C&R itself even cited permanent disability as being in issue, and that there are multiplicity of motivations and issues that could conceivably go into a party's agreement to resolve a case for a lump sum of money. It seems that the Board is mandating a specific agreement within the C&R regarding permanent disability before it could be considered an award for purposes of Labor Code § 4644(b).

Can parties submit evidence to show that the C&R was based upon an agreed amount of permanent disability? The Board in *Pasquotto* says no. The Board envisioned trials being held on the issue of what the parties meant when filling out a C&R, and decided that this would simply be too burdensome. It was decided that only the C&R document itself could be presented to demonstrate an “award of permanent disability”. If it does not sufficiently show an agreement as to what the permanent disability was, it is insufficient.

Nevertheless, *Pasquotto* was careful to point out that apportionment under Labor Code § 4663 remained available. That is, apportionment may still be had by showing that the prior injury was a cause of the ultimate disability. The Board took this opportunity to confirm an idea it had made reference to in *Sanchez* and *Strong.* Where Labor Code § 4664(b) does not mandate apportionment, it may still be shown, but the applicant still has the ability to demonstrate recovery and thus limit or eliminate the apportionment. The Board said "We now conclude that § 4663 does not preclude a showing that, prior to the injury or injuries for which the employee is now claiming permanent disability, he or she had medically rehabilitated from the disabling effects of an earlier industrial or non-industrial condition." So where the prior case was resolved by C&R, the “apportionment loophole” is alive and well.

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08. Labor Code § 5814 Revisited

Labor Code § 5814 has long been the subject of controversy due to its sometimes dramatic consequences. As is well known, Labor Code § 5814 provides for a 10% penalty where payment due for benefits is unreasonably late. In such an event, a penalty is assessed against not only the amount that is paid late, but also the entire species of benefit to which the applicant is entitled throughout the life of the claim. On the larger claims, this has made for what some view as an unfair windfall to the applicant.

In order to rectify this perceived abuse, the Legislature has made former Labor Code § 5814 inoperative as of June 1, 2004, and repealed it, as of January 1, 2005. This left people scratching their heads. However, it was also provided that the new § 5814 was instituted right away, to be operative as of the June 1 date. Furthermore, it was specifically indicated that this penalty reform applied to all injuries without regard to when they occurred. Case law has resolved any question as to when this new § 5814 applies. In the case of *Myron Abney v. Aera Energy* (2005) 70 CCC 460, an *en banc* decision, it was held that the new § 5814 applied to all dates of injury. In the case of *Green v. WCAB,* (2005) 70 CCC 294, the penalty issue had been through trial, and the Appeal was granted before oral argument SB 899 was enacted. It was decided that the new standards applied.

Therefore, it is clear that absent an absolutely final Award, with appeals exhausted, the new § 5814 applies. This standard was affirmed in *McCarthy v. WCAB* (2006) 71 CCC 16, *United Airlines v. WCAB (Conner)* (2005) 70 CCC 804 (this Appeals Court case contained a detailed discussion of the issue), *State Fund v. WCAB (Singleton)* (2005) 70 CCC 341, *Kastning v. WCAB* (2005) 70 CCC 637, and *Sonja Wells v. WCAB* (2005) 70 CCC 927. In *The Earthgrains Company v. WCAB* (2005) 70 CCC 1348, the retroactive statute was affirmed, but the Court did not disturb prior stipulations of the parties that had been entered into but not appealed.

The new statute on point amounts to an evisceration of the formerly high exposure for penalties. Applicant attorneys who specialized in this area have to start over. In October 2005 the governor vetoed a bill that had passed both houses; it would have instituted a new penalty of $2,000 or more for late payment following judicial award or order. It appears that the new statute is not going anywhere in the foreseeable future.

The new Labor Code § 5814 provides that "When compensation has been unreasonably delayed or refused, either prior to or subsequent to the issuance of an award, the amount of the payment unreasonably delayed or refused shall be increased up to 25%, or up to $10,000, whichever is less." This obviously is a substantial reduction in what would otherwise be owed, despite the higher potential percentage rate. It is clear that the WCJ has discretion here. The Legislature provides that the Appeals Board "shall use its discretion to accomplish a fair balance and substantial justice between the parties." In the writ denied case of *Stackhouse v. WCAB*

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(2005) 70 CCC 740, a WCJ's decision to only levy a 15% penalty was rejected. It was stated that "In the absence of evidence of any mitigating circumstances, the appropriate penalty to be imposed for the defendant's failure to timely pay temporary disability is 25% . . ." Therefore it looks like the WCJ's discretion to allow a less than maximum penalty is not very strong.

The Legislature provides that if the defense discovers an unreasonably delayed payment prior to the employee claiming a penalty, it may within 90 days of the date of that discovery self-impose a ten percent penalty. This is in lieu of the 25% penalty that would be due on the payment unreasonably delayed or refused. This self-assessment must be made before the applicant makes a claim for a penalty, and must be made within ninety days of the discovery of the "potential violation".

Note that Labor Code § 4650(d) has not been repealed. That section provides that when an indemnity benefit is paid late, it is to be increased by ten percent, regardless of whether the delay was unreasonable. Failure to comply with this requirement can result in a separate penalty under § 5814, old or new.

However, a new Labor Code § 5814(d) does allow that any payment under § 4650(d) reduces the liability under § 5814(a). Presumably then, if a $400 indemnity payment is paid late, $100 would be owed in penalty. A self-imposed penalty under § 4650 would also be owed in the amount of $40. However, this would reduce the original § 5814 penalty to only $60. In the *Stackhouse* case cited above, the WCJ refused to levy a penalty under Labor Code § 4650(d). He simply granted the penalty under Labor Code § 5814. The panel agreed with him that the § 4650 penalty was superfluous. It appears then that, absent a severely reduced § 5814 penalty, there effectively is no penalty under Labor Code § 4650.

The Legislature has provided some protection for the defense on issues of penalty in regards to resolution of cases. The new Labor Code § 5814(c) indicates that it is conclusively presumed that any claims for penalties have been resolved, whether a Petition for the penalty has been filed or not, when the Court approves a Compromise and Release, a stipulated award, or issues a Finding and Award, unless a claim for penalty is expressly excluded in the Order or Award. This has been reinforced by language contained in the new settlement forms recently put into use. Furthermore, it is conclusively presumed that any issue or claim for penalty has been resolved when the case is submitted for determination at a regular trial hearing, if the penalty issue has not been specifically raised in the pre-trial statement.

There is further protection available as well. The new Labor Code § 5814(e) indicates that "No unreasonable delay in the provision of medical treatment shall be found when the treatment has been authorized by the employer in a timely manner, and the only dispute concerns payment of a billing submitted by a physician or medical provider." This is a real change, as previously parties were able to request penalties based on an unreasonable refusal to pay a lien.

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In a final act of protection for the defense, the new Labor Code § 5814(g) indicates that "Notwithstanding any other provision of the law, no action may be brought to recover penalties that may be awarded under this section more than two years from the date the payment of compensation was due." This is a new statute of limitations for penalty issues.

Probably to address concerns regarding insurers or self-insured entities taking advantage of this situation to deliberately delay payments, Labor Code § 5814.6 is enacted, and provides for a $400,000 punishment for any organization that "knowingly violates § 5814 with a frequency that indicates a general business practice." Any assessment will be deposited in the Return-To-Work fund. This reform also became operative on June 1, 2004. At this writing, Regulations have been proposed (numbered 10225 through 10225.2) but not subject to public hearing in regards to this section. It appears from what has been proposed so far that substantial penalties will be considered.

In order to protect against employees trying to institute civil actions as a result of this section, Labor Code § 2699 of the Labor Code is amended. This section provides that employees can pursue civil penalties through a civil action on behalf of that person or other current or former employees where that civil penalty could otherwise be assessed and collected by the Labor and Workforce Development Agency or any of its Departments, Divisions, Commissions, Boards, etc. The new Subsection (k) of this Labor Code Section specifies that Labor Code § 2699 does not apply to the recovery of administrative and civil penalties in connection with the workers compensation law. In addition, Labor Code § 5814(f) states that "Nothing in this section shall be construed to create a civil cause of action."

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09. Reform of the Legal Standard

Labor Code § 3202 has long been a major weapon for applicants and their attorneys. It mandates that the workers compensation laws "shall be liberally construed by the courts with the purpose of extending their benefits . . ." This liberal construction rule has sometimes spilled over in questions of fact. It has been held, for example, that all reasonable doubts must be resolved in favor of the applicant when the issue of AOE/COE is being decided. This was held in the case of *Lundberg v. WCAB* (1968) 33 CCC 656. This case and its principle have been repeatedly referenced in subsequent decisions, such as *Maher v. WCAB* (1983) 48 CCC 326, even after the enactment of the original Labor Code § 3202.5 in 1983.

A tension has long existed between that principle and Labor Code § 3202.5, which held that § 3202 did not relieve the applicant and lien claimants from meeting their burdens of proof. Labor Code § 3202.5 now states that "All parties and lien claimants shall meet the evidentiary burden of proof on the issues by a preponderance of the evidence in order that all parties are considered equal before the law."

The exact effect of this new language is uncertain. Certainly, questions of law are still to be liberally construed in favor of the applicant. However, this new language evinces a legislative intent to limit this liberal bias, and perhaps keep it altogether out of questions of fact.

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10. Clean-Up Legislation

A variety of provisions in this new set of statutes seem to have been put into place at least in part to "clean up" some of the enactments of the 2003 legislation.

A. Vocational Rehabilitation

Labor Code § 139.5 had been completely repealed. This had been confusing to some, since the voucher system was not put into place except for injuries on or after January 1, 2004. Accordingly, it was wondered how the Vocational Rehabilitation Bureau was going to continue to exist, and how there would be a legal basis for their decisions for injuries preceding that date.

Accordingly, Labor Code § 139.5 has been re-added to the Labor Code. It has one extra provision; the statute will remain in effect only until January 1, 2009. It will then "sunset" unless the legislature takes further action.

Note that the repeal of § 139.5 in its present form is not a repeal of the voucher system. That system was enacted in 2003 in its entirety in two separate Labor Codes. Labor Code § 4658.5 independently provides for the existence of the entire voucher system.

Rehabilitation must be completed by 12/31/08, at which point Labor Code § 139.5 expires ("sunsets"), and there will be no more statutory authority for the provision of this benefit.

B. Fraud

Labor Code § 3823 is part of the 2003 legislation. A variety of persons were charged with the duty of reporting fraud when they became aware of the same. This caused a fear of liability, as any "apparent fraudulent claim" had to be reported. We now have Labor Code § 3823(c), which indicates that those persons reporting this apparent fraud are not subject to civil liability, as long as they act in good faith without malice, and reasonably believe that the action taken was warranted by the known facts. This is of only limited comfort.

C. Utilization Review

There are a variety of items here which are obviously intended to reinforce and better define utilization review, which was of course a major part of the 2003 legislation. One of these areas, the definition of utilization review as "reasonable" in accordance with Labor Code § 4600, has already been described in the text of this review. We have also seen the requirement that the applicant object if displeased with a decision to delay, refuse or modify a request for medical treatment.

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In addition, we have new language added to Labor Code § 4604.5. This refers to the presumption in favor of utilization review guidelines. The question of the strength of that presumption had been raised by some following the 2003 legislation. However, new language is added here that “The presumption created is one affecting the burden of proof.” This is no doubt intended to rectify any question in that area. Also, overcoming the presumption requires scientific medical evidence.

This provision takes effect right away as noted herein. Finally, it should be noted that throughout the entirety of this Bill the authors have taken care to reinforce the seriousness of utilization review wherever appropriate.

D. Collective Bargaining Agreements

The 2003 law established a collective bargaining agreement between a private employer or groups of employers engaged in certain industries with their unions to create a dispute resolution process and terms for workers' compensation in general. Labor Code § 3201.5 is now amended to allow the parties to negotiate any aspect of the delivery of medical benefits, and the delivery of disability compensation to the employees who are eligible for group health benefits and non-occupational disability benefits. This is a possibly serious opportunity for these sorts of organizations. Final Regulations §§ 10200-10204 went into effect on this effective October 4, 2004.

F. Safety Program Changes

As part of the 2003 legislation, each insurer was required to establish and review an injury prevention program with its insureds. The program was to be reviewed within four months of writing a new policy. This standard has been replaced; the insurer now has to only review the programs of insureds with experience modifiers of 2.0 or greater to determine whether the insured has implemented the program within six months of writing the initial policy. This gives the insurers a little more room to breathe.

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