

## 2007 Cases of Interest

### Jurisdiction

*Duran v. WCAB* (72 CCC 488): In this case the WCAB reversed the WCJ and held that, under Labor Code § 5410, it had no jurisdiction to award TD more than five years after the date of applicant's injury, even if the applicant filed a timely petition to reopen. The applicant was injured on 8/7/2000, received a stipulated award on 4/25/2005, and filed a petition to reopen on 7/6/2005 (within five years of the date of injury). The new period of TD began on 11/11/2005, more than five years after the date of injury. This is the same result that was reached in *Gomez v. WCAB* (71 CCC 1721), where the 5<sup>th</sup> District Court of Appeal held the WCAB has not jurisdiction to award temporary disability that begins more than five years after the date of injury, even if there was a timely petition to reopen.

By contrast, in *Sarabi v. WCAB* (72 CCC 778), the Court of Appeal held that the WCAB had jurisdiction to order additional TD benefits more than five years after the date of injury because applicant had filed a timely petition to reopen and his new and further disability (need for TD benefits) began within five years of his date of injury. The applicant had a need for the benefits, and defendant was initially providing them to the applicant, but then terminated under the belief they did not have to pay TD after five years. Because the need for TD arose before the five year statutory period expired, the WCAB retains jurisdiction.

In *Shannon v. CIGA* (35 CWCR 216), the Court of Appeal held that the WCAB had no jurisdiction to award TD more than five years after the date of injury. Applicant sustained an industrial injury on 4/16/97. By way of an F&A on 6/11/98, applicant was found to have sustained injury and was awarded ongoing TD benefits beginning 4/19/97. In 2004, defendant filed a petition to terminate liability for TD benefits, and that petition was granted on 8/2/04. On 6/2/05 there was an expedited hearing on the issue of surgery and need for TD. The panel rescinded the TD award stating that the WCAB had no jurisdiction to award TD as it was more than five years from the date of injury and there was not a timely filing of a Petition to Reopen.

This is interesting in that the other cases all dealt with prior awards of permanent disability. In *Shannon*, there was no award of PD, but there had been an award of TD and an order terminating those benefits.

### Injury AOE/COE

In *Matea v. WCAB* the 6<sup>th</sup> District gave an example of what constitutes a sudden and extraordinary event as an exception to Labor Code § 3208.3(d). In this case the applicant sustained an orthopedic injury when a large amount of lumber fell. The

applicant had not been employed for six months at the time of the orthopedic injury and alleged a psychiatric compensable consequence claim. The court relied on definitions of "sudden" and "extraordinary" and held that a rack of lumber falling was not an incident that happened in the regular course of business and was not expected to occur, thereby meeting the exception of a sudden and extraordinary event.

*Puga v. WCAB* (72 CCC 195): This case dealt with the sudden and extraordinary exception to the six-month employment rule for psychiatric injuries as a compensable consequence of an orthopedic injury. In *PGA* the applicant sustained an admitted back injury after falling from a ladder while inspecting and fixing ceiling fans in a chicken house, approximately two months after beginning employment. This occurred during her regular and routine employment duties. She then filed a psychiatric claim as a compensable consequence. The Court of Appeal denied the applicant's writ for review and affirmed the WCAB's holding that the psychiatric injury was not compensable.

By contrast, in *CIGA v. WCAB (Tejara)* (72 CCC 482), the WCAB found that applicant did sustain a compensable psyche injury as a result of an auto accident where the applicant was driving a truck and trailer, lost control on a wet highway, the trailer jackknifed and the applicant was thrown to the passenger side of the truck and out the passenger side door, the steering wheel came loose and the trailer almost ran over his feet. While the WCAB found that motor vehicle accidents generally are not extraordinary events, the circumstances here were sufficient to qualify as extraordinary, allowing applicant to pursue a psychiatric claim even when he had not worked for the employer for six months and the "sudden and extraordinary employment condition" exception of Labor Code § 3208.3(d) applied.

### **Presumptions/Public Employees**

*City of Oakland v. WCAB (Aisthorpe, Watson)* (72 CCC 249): In this writ denied case, the WCAB held that salary continuation benefits paid under Labor Code § 4850 are not subject to the two year limitation of temporary disability as set forth in Labor Code § 4656, as amended by SB 899.

### **Medical Treatment & Legal Expenses**

*Smith v. WCAB; Amar v. WCAB* (72 CCC 27): In this case, the Court of Appeal annulled a WCAB decision and held that an applicant's attorney who succeeded in enforcing an award for future medical care was entitled to received attorney's fees for their efforts, even if defendant did not institute proceedings to terminate liability for medical care under Labor Code § 4607. The Court of Appeal saw no difference between an informal denial of treatment versus a formal denial.

*Babbit v. Ow Jing* (72 CCC 70): In this en banc decision, the WCAB held that the MPN statutes do apply retroactively, regardless of date of injury. The WCAB held that MPN statutes only made procedural changes, and did not affect any substantive rights, and therefore could be applied retroactively.

*City of Hayward v. WCAB (Rushworth-McKee)* (72CCC 237): In this writ denied case, the WCAB held that a defendant who obtains a UR report under Labor Code § 4610 approving surgery, was not entitled to obtain a second opinion from a QME under Labor Code § 4062 before an expedited hearing.

*Brasher v. WCAB* (72 CCC 229): In a significant panel decision, the WCAB reversed the WCJ's decision and held that defendant, in response to a request by a treating physician for spinal surgery, has the options of (1) authorizing surgery, (2) objecting to surgery pursuant to Labor Code § 4062(b) by filing a DWC Form 233 within 10 days of receiving the recommendation, (3) submitting the recommendation to UR, or (4) pursuing options (2) and (3) simultaneously or by filing objection after UR denial, meeting the time lines for each process, that, if defendant denies surgery pursuant to UR, the applicant must object within 10 days of receipt of defendant's denial, and that dispute will then be resolved under the second opinion procedures set forth in Labor Code § 4062(b).

In *Sacramento County Office of Education v. WCAB (Burnett)*, the Court of Appeal held the defendant was not liable for the costs of a spinal surgery that was self-procured before a renewed second-opinion process was resolved. In the case, the applicant suffered a back injury in June 2001 that was resolved by Stipulated Award in January 2003. A petition to reopen was filed in November 2005. In October 2004 spinal surgery was first recommended. Defendant withheld authorization pending consultation with a second opinion physician under Labor Code § 4062(b). Applicant's attorney agreed that they would abide by the decision of the agreed upon second opinion physician regarding surgery. Dr. Robbins, the agreed upon physician, provided a report in April 2005 that did not recommend spinal surgery. In a supplemental report in July 2005, he stated, "Although the scan does seem to show a slight worsening of her disc protrusion, my problem with the patient continues to be the lack of congruity between symptoms and the different tests that she has been having. The discogram showed left-sided pain, yet her disc herniation seems to be on the right. There do not seem to be consistent symptom complaints of right leg pain by the patient. . . .Again, I could not fault [the secondary physician] if at this point in time he attempted to go in and take the disc out, but I would question whether the patient's symptoms . . . and the objective findings on scans are all correlative in nature." Surgery was denied by the defendant and applicant's counsel agreed to be bound by that report. Applicant's condition further deteriorated in September 2005 and applicant obtained a new attorney. In October 2005 the applicant demanded temporary disability and surgery and filed the Petition to Reopen in November 2005. The applicant's new treating physician again recommended surgery in December 2005. The employer filed an objection to the surgical recommendation because there was not an updated opinion from Dr. Robbins.

Applicant underwent the surgery in January 2006 and defendant denied payment of the same. The court held that this surgery was performed before the second opinion process was completed and defendant was not liable for payment for the surgery.

*Glagola Construction Co v. WCAB (Larios) (72 CCC 1016)*: the WCAB awarded applicant construction carpenter/laborer further medical treatment to cure or relieve effects of his 12/18/2004 injury AOE/COE to low back and spine, including, but not limited to, two-level arthroplasty disc surgery recommended by applicant's treating physician and supported by AME, based on opinions from treating surgeon and AME and applicant's offer of proof, when applicant previously underwent failed lumbar laminectomy and hemilaminectomy for his injury, his treating surgeon recommended either two-level arthroplasty disc surgery (using artificial discs) or arthrodesis/fusion but found arthroplasty disc surgery was also reasonable and supported choice of type of surgery made by applicant and treating surgeon, AME stated that treating surgeon was excellent surgeon, WCAB found that suggested surgery was outside ACOEM Guidelines, or, alternatively, that it was within Chapter 6 of Guidelines, which stated that treatment to increase function in chronic pain patients was appropriate, and there was not authority for defendant's contentions that requested surgery should be denied because it was experimental or not supported by FDA

### **Disability Indemnity**

*County of San Joaquin v. WCAB (Davis) (72 CCC 187)*: In this case the Court of Appeal affirmed the WCAB's determination that applicant was entitled to maximum earnings by applying Labor Code § 4453(c)(4). The Court of Appeal found that applicant's regular employment as an attorney made him eligible for maximum earnings, and that the fact he was injured while on jury duty, earning minimal wages, did not justify paying him minimum indemnity rates.

### **Temporary Disability**

*McCray v. WCAB (72 CCC 493)*: This case deals with payment of TTD during a period of non-industrial treatment required to treat an industrial injury. The WCAB reversed the WCJ and held that applicant was *not* entitled to TTD from 2/24/2006 to present and continuing for a 7/28/95 admitted right knee and lumbar spine injury. The WCAB found that while treatment for non-industrial obesity could be compensable as necessary to treat the industrial injury, it wasn't in this case because the applicant needed a total knee replacement on an industrial basis, AME indicated that applicant needed to lose 125 to 150 pounds before undergoing surgery, defense QME indicated that applicant would never lose the necessary weight, applicant's weight had not changed significantly after 15 months, applicant's treating physician's report on TTD was not persuasive and the WCAB relied on opinions from AME and defense QME that applicant could work with a semi-sedentary work restriction.

## **2-Year TTD Rule (Labor Code § 4656(c))**

SB 899 amended Labor Code § 4656(c) to provide that aggregate disability payments for a *single injury* causing temporary disability shall not extend for more than 104 compensable weeks within a period of two years from the date of commencement of temporary disability payments, however, there are certain exceptions to this rule.

As noted above in *City of Oakland v. WCAB (Aisthorpe, Watson)*, the court held the two-year rule does not apply to benefits paid under Labor Code § 4850. This would essentially give those applicant's who are entitled to Labor Code § 4850 benefits, at total of three years of potential temporary disability benefits.

There is currently a difference of opinions as to whether industrial disability leave payments are counted towards the 104-week cap. There are no cases, however, that are dispositive on the issue, and as such it should be argued that those payments are part of the aggregate period of temporary disability.

In *Hawkins (72 CCC 807)*, the WCAB, en banc, determined that the period of two years begins on the date that temporary disability was first paid, not the date upon which it was first owed. Therefore, if temporary disability is owed, but not paid due to a dispute over the compensability, the two-year cap would begin with the first date of payment of the benefits. There was a dissenting opinion, and if the case is appealed it could turn on the dissenting opinion and the use of the word "aggregate" in the plain language of the statute.

The other issue that is starting to be raised, but has not been determined by the full WCAB or a Court of Appeal, is what it means to have a *single injury*. Judges are determining that this means if applicant has filed more than one claim of injury, i.e., a specific and a cumulative trauma injury, that applicant would be entitled to two 104-week limits on temporary disability. On the other hand, there is at least one Judge who has ruled that if there is more than one injury, Labor Code § 4656(c) doesn't apply at all.

There have been a series of trial level decisions that have recently been issued regarding the application of Labor Code, section 4656(c). This section provides for exceptions to the 104 week temporary disability limits, allowing 240 weeks of temporary disability benefits under certain circumstances, including amputations.

There have been two trial level decisions issued in Northern California that have held that spinal surgeries that remove bone and disk material meet the legal definition of an amputation, and thus extend temporary disability beyond the 104 week cap.

In *Kirkpatrick v. Dominican Santa Cruz Hospital (SAL 107786)*, the WCJ reasoned that "[p]ortions of the body were removed from both the neck and hip, . . . the question becomes what is an amputation." The WCJ found that "while the term amputate can mean either cutting off a body part, a more specific definition of amputation refers to removal of a part

or all of a body part 'enclosed by skin.'" By adopting this definition, the WCJ awarded temporary disability beyond the 104 week limit.

A second WCJ in Northern California also awarded temporary disability beyond the 104 week limit after an applicant underwent a bilateral laminotomy and decompression. The WCJ reasoned that "[a]s the surgeons herein actually removed a portion of the applicant's entire spine and hip as part of the surgery, it would appear that this would come within the general definition of an amputation..."

However, in Los Angeles, in the case of *Murillo v. Hi Point/Norco Ranch* (LAO 848876), a WCJ declined to extend an applicant's temporary disability beyond the 104 week limit, finding that a disk removal is not an amputation for purposes of Labor Code, section 4656(c). The WCJ adopted the definition of amputation to be "a word that describes the cutting off or removal of a limb or other appendage from the body. An appendage is a part of the body that sticks out."

**NOTE:** On September 4, 2007, the WCAB issued an *en banc* decision holding that back surgery is NOT an amputation, and therefore, will not act as an exception to Labor Code § 4656(c). Specifically, the WCAB stated, "we hold that the word "amputations," as used in section 4656(c)(2)(C), means the severance or removal of a limb, part of a limb, or other body appendage, including both traumatic loss in an industrial injury and surgical removal during treatment of an industrial injury. This definition conforms to our understanding of the common meaning of the term "amputation," which encompasses external projecting body parts, not internal parts, even if they include bone.

This will now hopefully resolve the issue of whether back surgery qualifies as an amputation for purposes of extending the 104-week cap on temporary disability under Labor Code § 4656(c).

## **Permanent Disability**

### **Apportionment**

*Pasquatto v. Hayward Lumber:* In this case we learned that a Compromise and Release, without more, is not an award of permanent disability for purposes of Labor Code § 4664(b). As of today, there are no cases that have dealt with the issue of what constitutes "something more." As such, if you have a prior Order Approving Compromise and Release, you will not be able to obtain a conclusive presumption under Labor Code § 4664(b), but you can use the medical evidence from that earlier case to establish apportionment under Labor Code § 4663.

In *Kopping v. WCAB*, the court concluded "the Legislature intended the section 4664(b) presumption to be conclusive, not rebuttable, notwithstanding the second sentence of the statute. It further held the employer "has the burden of proving overlap between the

current disability and the previous disability in order to establish its right to apportionment of . . . permanent disability. A prior permanent disability award is conclusively presumed to exist, and the employer has the burden to establish that the prior award overlaps with the current level of disability in order to obtain apportionment.

In *Yeager Construction Co v. WCAB (Gatten)*, the court held that in establishing apportionment under Labor Code § 4663, there does not have to be actual pre-existing disability. The WCJ and WCAB had rejected a physician's opinion that 20% of the applicant's disability was due to mild and non-disabling degenerative disc disease. The court of appeal noted that if the WCAB's opinion were to be followed, apportionment under Labor Code § 4663 would rarely be found.

*Sierra Bible Church v. WCAB (Clink)* (72 CCC 20): The Court of Appeal upheld WCAB's award of 77-percent PD, without apportionment, based upon AME's initial medical reporting. The Court of Appeal found that the AME's trial testimony was subject to interpretation and less than definitive on the subject of apportionment, and that defendant did not meet its burden to prove apportionment.

*Fry's Electronics, Inc v. WCAB (Daryabeghi-Moghadam)* (72 CCC 131): In this writ denied case, the WCAB held that the defendant's QME's opinion on apportionment was not substantial evidence because, although it indicated that applicant had pre-existing pathology, it failed to explain how the pathology caused disability or how the doctor determined apportionment of 25 percent

*Markham v. WCAB* (72 CCC 265): In this writ denied case, the WCAB reversed the WCJ's opinion and found that AME's opinion supported a finding of apportionment, when he gave the opinion that the applicant's knee replacement surgery was necessitated by both industrial injury and "other factors" in form of pre-existing pathology, explained the approximate percentage of disability caused by industrial injury and stated his opinion in terms of reasonable medical probability.

*Marsh v. WCAB* (72 CCC 336): In this case, the Court of Appeal denied the applicant's petition for writ of review and held that the WCAB's finding that 50 percent of the applicant's PD was caused by non-industrial factors was supported by substantial evidence because the AME's opinion was supported by sufficient reasons as to how and why the disability was 50-percent caused by osteopenia.

*Gossett v. WCAB* (72 CCC 675): The WCAB reversed an arbitrator's finding and held that 15 percent of applicant's PD should be apportioned to underlying asymptomatic arthritis pursuant to the QME's opinion. The WCAB found that the QME's opinion met the requirements set forth in *Escobedo v. Marshalls* to establish apportionment under Labor Code § 4663 since the QME explained that his opinion was based on the severity of applicant's arthritis noted on imaging studies, and that a reference in the QME's report indicating that his opinion on apportionment may be speculative was merely surplus language that did not undermine opinion.

*Paredes v. WCAB (2007) 72 CCC 690*: In this writ denied case, the WCAB reversed the WCJ's finding and held that 10 percent of applicant's PTD stemming from successive injuries to his back, neck, and upper extremities should be apportioned to non-industrial degenerative changes pursuant to AME's opinion, when WCAB found that AME's opinion met requirements set forth in *Escobedo v. Marshalls* to establish apportionment under Labor Code § 4663(a), as enacted by SB 899, since opinion indicated that applicant's non-industrial pathology caused PD, and that neither AME's inability to state with medical probability that applicant would have sustained PD absent work injuries nor his approximation of PD caused by non-industrial factors made his opinion speculative

### **Application of 2005 PD Rating Schedule**

*State Compensation Insurance Fund v. WCAB (Echeverria) (72 CCC 33)*: Court of Appeal annulled a WCAB decision which applied the 1997 PDRS, when it found that a 12/15/2004 single-sentence report by the PTP indicating that PD was within reasonable medical probability, did not constitute substantial evidence as it did not indicate the reasoning behind the physician's opinion.

*Baglione v. Hertz Car Sales (72 CC 86)*: In this en banc decision, the WCAB held that because a comprehensive medical report issued prior to 1/1/2005, the 1997 PDRS applied, even though the medical-legal report did not indicate an existence of PD. The WCAB applied the last antecedent rule to the wording of Labor Code § 4660(d). **NOTE**: This case was reversed on a Petition for Reconsideration of the original en banc WCAB ruling. In *Baglione v. Hertz Car Sales (72 CCC 444)*, the WCAB en banc, held that for compensable claims arising before 1/1/2005, in order for 1997 PD rating schedule to apply, pursuant to Labor Code § 4660(d), existence of PD must be indicated in either pre-2005 comprehensive medical-legal report or pre-2005 report from treating physician, and that, otherwise, 2005 PD rating schedule applied. They based the opinion on the "urgency" nature of SB 899, indicating that it sought to provide relief from the state's workers' comp crisis "at the earliest possible time," and no rationale existed for delaying use of 2005 schedule merely because a comprehensive medical-legal report had issued, even if it did not indicate the existence of permanent disability.

*Pendergrass v. Duggan Plumbing (72 CCC 95)*: In this en banc decision, the WCAB held that for purposes of determining which schedule to use pursuant to Labor Code § 4660, the employer's duty to provide notice required under Labor Code § 4061 arises with the first payment of temporary disability, so that if the first date of compensable TD is prior to 1/1/2005, then the 1997 PDRS applies. The WCAB distinguished between when the duty arises and when it is to be executed. **NOTE**: This case was reversed on a Petition for Reconsideration of the original en banc WCAB ruling. In *Pendergrass v. Duggan Plumbing (72 CCC 456)*, the WCAB en banc, held that for compensable claims arising before 1/1/2005, only if the last payment of TD indemnity was made for any period of TD ending before 1/1/2005 would the 1997 PD rating schedule apply, because Labor Code § 4061 required defendant to provide applicant with notice regarding PD "[t]ogether with the

last payment of temporary disability indemnity,” and that otherwise 2005 PD rating schedule applied. The WCAB found that “plain language” of Labor Code §§ 4660(d) and 4061 state that defendant’s obligation to provide notice did not arise until actually last payment of TD indemnity in 7/2005, and that the “urgency” nature of SB 899 sought to provide relief from the state workers’ comp crisis “at the earliest possible time.”

*Trader Joe’s Co v. WCAB (Everts) (72 CCC 204)*: The Court of Appeal vacated a portion of the WCAB’s award, and found there had been no treating physician’s report prior to 1/1/2005 indicating the existence of permanent disability and that the WCJ’s observation that applicant’s injuries were a type described in the AMA *Guides* did not indicate the injuries were necessarily permanent, and no pre-1/1/2005 report gave an indication that applicant’s disability would be permanent.

*Escutia v. WCAB (72 CCC 254)*: In this writ denied case, the WCAB held the 2005 PDRS applied when it found that a report from applicant’s treating physician stating he was sending the report to “indicate the existence of PD” and checking off boxes indicating that applicant was not yet P&S but would have PD, did not constitute substantial evidence and was insufficient to require application of the 1997 PDRS.

*Washington Mutual Card Services v. WCAB (Gaines-Hills) (72 CCC 278)*: In this writ denied case, the WCAB held the 1997 PDRS applied to applicant’s injuries both because there was a treating physician’s report which issued on 11/23/2004 stating the applicant had PD and listed the applicant’s physical limitations, which were identical to the limitations listed in the 8/30/2005 P&S report, and because it found that the duty to give notice to applicant under Labor Code § 4061 attached prior to 1/1/2005 when applicant began receiving EDD benefits and the defendant’s obligation to pay TTD commenced, both of these situations giving rise to exception in Labor Code § 4660(d).

*Tokio Marine and Fire Insurance Company v. WCAB (Carmela Burnside) (2007) 72 CCC 731*: In this writ denied case, the WCAB held the 1997 Schedule for Rating PD applied when the WCAB found that a form RU-90 prepared by applicant’s treating physician on 7/1/2004 stating that applicant was QIW and entitled to vocational rehabilitation constituted a report indicating the existence of PD sufficient to satisfy the exception to the application of the 2005 PD Rating Schedule, despite the fact that applicant underwent surgery one week after the form was prepared.

In *Costco Wholesale Corp v. WCAB (Chavez) (72 CCC 582)*, the Court of Appeal annulled a WCAB award that applied the 1997 schedule and remanded the case for recalculating the applicant’s rating using the 2005 PD rating schedule because the QME report that issued on 9/24/2004 did not indicate the existence of PD and, therefore, did not permit the use of the old schedule under Labor Code § 4660(d). The Court of Appeal also found that since applicant received TD benefits from 10/20/2004 until 6/28/2005, the new schedule would apply since Labor Code § 4061 notice was not due until the last payment of TD in 2005, and Labor Code § 4660(d) only permitted use of the old schedule if the Labor Code § 4061 notice was required prior to 1/1/2005.

In *Zenith Insurance v. WCAB (Azizi)* (72 CCC 785), the Court of Appeal, annulled a WCAB award of PD that applied 1997 schedule for rating PD, and agreed with *Costco Wholesale Corp v. WCAB (Chavez)* and *Pendergrass v. Duggan Plumbing*, holding that 2005 PD rating schedule should be applied to applicant's 10/21/2004 industrial injury, when Court of Appeal found that defendant paid applicant TD between 10/21/2004 and 8/5/2005, that defendant was required to provide notice under Labor Code § 4061 "together with the last payment of temporary disability indemnity," i.e., in 8/2005, and that defendant was, therefore, "not required to provide the notice required by Section 4061 to the injured worker," pursuant to Labor Code § 4660(d), prior to 1/1/2005

Additional cases which have ordered the use of the new schedule are:

*Chang v. WCAB* (72 CCC 921): Court of Appeal held that WCAB correctly relied on 2005 PD rating schedule in determining applicant's level of PD from cumulative trauma injury ending 7/2004, since none of exceptions set forth in Labor Code § 4660(d) applied, when Court of Appeal, following *aldi v. Carr, McClellan Ingersoll, Thompson & Horn*, found that Administrative Director could have promulgated 2005 PD rating schedule prior to 1/1/2005 deadline mandated by Labor Code § 4660(e) did not mean that, only if new schedule had been promulgated between 4/19/2004 (effective date of SB 899) and 1/1/2005 would new schedule have applied to injuries sustained during 2004, nor did fact that new schedule did not become effective until 1/1/2005 mean that exceptions in Labor Code § 4660(d) became moot so that all injuries occurring before 1/1/2005 were to be rated under 1997 schedule for rating PD

*Energetic Painting and Drywall, Inc v. WCAB (Ramirez)* (72 CCC 937): Applied the new schedule when defendant paid TD benefits from 7/13/2004 through 3/24/2005 and that, as held in *Pendergrass v. Duggan Plumbing* and *Costco Wholesale Corp v. WCAB (Chavez)*, plain language of Labor Code §§ 4061 and 4660(d) compelled conclusion that defendant was not required to provide applicant with Labor Code § 4061 notice until 3/2005, when applicant's TD benefits ended, and, therefore, that no exception listed in Labor Code § 4660(d) justified use of 1997 schedule

*Joiner v. WCAB* (72 CCC 943): The Court of Appeal held that WCAB correctly relied on the 2005 PD schedule for a 7/10/2002 injury when the parties had stipulated that none of the conditions set forth in Labor Code § 4660(d) existed and that the second and third sentences do not negate each other, instead the third sentence merely creates exceptions for pre-2005 injuries

*Minatta Transportation Co v. WCAB (Lanning)* (72 CCC 950): Relying on *Costco Wholesale Corp v. WCAB (Chavez)*, it was held applicant's PD award should be calculated using 2005 PD rating schedule, when Court of Appeal found that defendant had complied with Labor Code § 4061 when it mailed required notice to applicant after last TD payment was made in 7/2005

*Washington Mutual Bank v. WCAB (Helm)* (72 CCC 962): The Court of Appeal held that WCAB should have used 2005 PD rating schedule, when Court of Appeal found that, although pre-2005 comprehensive medical-legal report existed, it did not indicate existence of PD, so that, pursuant to *Costco Wholesale Corp v. WCAB (Chavez)*, such report did not justify use of 1997 schedule, and that, although pre-2005 treating physician's reports existed, references in those reports to PD did not constitute substantial evidence since physician failed to support references with any reasoning

### **Apportionment Calculation**

*Brodie v. WCAB; Welcher v. WCAB; Strong v. WCAB; Lopez v. WCAB; Williams, Jr. v. WCAB* (72 CCC 565: In probably one of the most publicized and hotly contested cases, the Supreme Court addressed the way to calculate permanent disability after apportionment. The Supreme Court held that "Formula A" adopted by the Court in *Fuentes v. WCAB*, pursuant to which percentage of disability attributable to new injury is calculated by subtracting old PD rating from new PD rating, then consulting table for ward due this difference, remains the proper method for calculating apportionment. The Court found that neither the plain language of SB 899, nor legislative history gives any evidence of an intent to abandon "Formula A" in apportionment cases.

### **Reconsideration/Removal**

*Nestle Ice Cream Co, LLC v. WCAB (Ryerson)* (72 CCC 13): The Court of Appeal annulled the WCAB's decision and found that defendant's petition for reconsideration which was timely filed as to the WCJ's amended award, but not to the original award, was timely filed because the amended award made a substantial material change in the award and involved an exercise of judicial function.

### **PENALTIES**

In *New United Motors Manufacturing, Inc. v. WCAB (Gallegos)* it was determined if an insurer discovers a late payment and issues a self-imposed 10% penalty, it can avoid a 25% penalty under Labor Code section 5814, as long as the penalty is paid within 90 days of the date of the employer's discovery, and before the filing of a penalty petition by the applicant. This case holds that it does not have to be the employer who discovers the late payment, only that the late payment and issuance of the self-imposed penalty must be made prior to the filing of a penalty petition to avoid the penalty under Labor Code section 5814.

## **OTHER ISSUES**

### **ACOEM Guidelines**

In *Sierra Pacific v. WCAB (Chatham)*, the court held that ACOEM guidelines apply to all cases pending at the time of SB 899. In this case, the treatment had occurred prior to the adoption of the guidelines. The court held the ACOEM guidelines should apply anyway, based upon the urgency legislation and paragraph 47 of SB 899.

In *Providence St. Joseph Medical Center v. WCAB (Gharabaghi)* the WCAB held that an applicant was entitled to an artificial disc replacement surgery for his admitted back injury when the AME recommended the surgery and the recommendation was corroborated by FDA studies on the success of artificial disc replacements, which rebutted the ACOEM Guidelines, after a UR physician recommended against the surgery.

### **Psychiatric Injuries**

In *Sonoma State v. WCAB (Hutton)* the court held that the employment must be the predominate cause of a psychiatric injury. This applies to all diagnoses. In *Hutton*, the applicant had several psychiatric diagnoses. In one, the doctor found the predominate cause to be the job, but not as to the others. The court held that the employment must be predominate at to all causes.

### **Death Benefits**

In *Six Flags v. WCAB*, the trial judge awarded \$250,000 to the deceased's estate (Labor Code § 4702(a)(6)(B)) as well as \$125,000 to the Death Without Dependents Unit. The court held the award to the estate was unconstitutional because the California Constitution does not identify estates as a class of beneficiaries for workers' compensation benefits.

Along the same lines, and for the same reasons, the Court of Appeal annulled a WCAB decision awarding death benefits to decedent worker's estate in *State Compensation Insurance Fund v. WCAB (McMahon)* (72 CCC 37)

### **Surgery Center Liens**

In *Pfeffer v. Fisher Construction* (POM 0252332–5/7/07), the WCAB denied reconsideration and identified the *correct legal standards* for outpatient surgery facility fees incurred before the January 1, 2004 effective date of Labor Code § 5307.1(c). The central question in determining a surgery center facility lien is whether the fee is "reasonable." This is pursuant to *Kunz v. Patterson Floor Covering, Inc.* (2002) 67 CCC 1588. The surgery center, in its petition for reconsideration, argued that the burden is on the defendant to establish that the fees are unreasonable. Instead, the WCAB held, "it is the *lien claimant* that has the affirmative burden of proving that its charges are *reasonable*, and it must carry this burden by a preponderance of the evidence." Under the findings in *Kunz*, absent other evidence, the surgery center's billing will normally establish (1) what it usually accepts for the services rendered, and (2) what other medical providers in the same

area generally accept. Although the billing can be prima facie evidence on those two points, the billing does not automatically establish that the fees are reasonable. The prima facie evidence can also be rebutted, and a facility fee charged by a surgery center will not be “reasonable” if the fee charge is “grossly disproportionate” to what is charged by other facilities. In this particular case, the lien claimant billed \$65,000 in fees for the services rendered on June 9, 2003. At trial, defendant was prepared to present the testimony of an expert witness who would have testified that the average fee in an inpatient facility for the same are would have been \$6,593.12. The lien claimant stipulated to the qualifications of the expert and stipulated the amount “accurately reflects the DRGs for the services in question.” The WCAB held, “In light of the legal principles discussed above, it was entirely proper for the WCJ to find that \$6,593.12 is the “reasonable” value of lien claimant’s services and to reject the balance of lien claimant’s \$65,000 charges. . . . Indeed, an outpatient surgery center facility fee that is nearly ten times as great as the fee that inpatient facilities could legally receive for the same services shocks the conscience and is manifestly unreasonable.”

In *Jimenez v. Galaxy Shade Systems* (ANA 0377538–6/11/07), the WCAB again held that the lien claimant (surgery center) has the burden of establishing the reasonableness of its fees. “Because it was *lien claimant’s* burden to affirmatively prove its case, the WCJ erred in holding that the lien should be allowed in its entirety because of the *defendant’s* failure to raise the issue of the reasonableness of the claimed charges as an issue.” It further held, “We believe that the WCJ misapplied our holding in *Kunz*. Nowhere does the *Kunz* alter the axiomatic rule that the lien claimant has the burden of proving the reasonableness of the amounts charged.

If you would like further information regarding any of these cases, please do not hesitate to contact our offices.