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QUARTERLY REVIEW

Fourth Quarter 2008

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A Legal Update for the Claims Professional

POST SANDHAGEN:

IS BRASHER STILL GOOD LAW?

By Jerry Rempel, Chico Branch Manager

On July 3, 2008, the California Supreme Court ruled, in *State Compensation Insurance Fund v. WCAB (Sandhagen)* (citation), that employers, and their insurers or third party administrators, cannot object to medical treatment requests under LC §4062(a) that are covered under LC §4610. The Court stated that this requires the employer to use Utilization Review (UR) “when resolving *any and all* requests for medical treatment.”

In summary, §4062(a) simultaneously *precludes* employers from using its provision to object to employees’ treatment requests but *permits* employees to use its provisions to object to employers’ decision regarding treatment requests under §4610. They stated that “the Legislature’s intent regarding employers’ use of §4062 to dispute treatment requests could not be more clear.”

Regardless of the clarity of the legislative intent regarding LC §4062(a), the Court repeatedly referred to §4062, and it specifically refers to any and all medical treatment requests. So the question now is whether employers are required to use UR with respect to requests for authorization for spinal surgery.

The WCAB addressed this issue in the case of *Brasher v. Nationwide Studio Fund* (2006) (citation). In that case, the Board held that employers have four options when a treating physician requests spinal surgery. They can authorize the surgery, object to the surgery, pursuant to LC §4062(b), submit the recommendation to UR, or object to the surgery and pursue UR simultaneously.

The next question, in light of *Sandhagen*, is whether *Brasher* is still good law. Given that *Sandhagen* purports to be a case of strict statutory construction, I believe *Brasher* is still good law.

The Court did say that UR applies to any and all medical treatment requests, and an employer is *required* to use the UR process for all treatment requests. However, the decision does not specifically address §4062(b), which states that an employer may object to a request for spinal surgery. There is no mention of §4610 in §4062(b). Does this mean that an employer can *only* use UR to address spinal surgery requests? In addressing this issue, one must look to the context in which the Court uses the *any* and *all* language. Since the entire case addresses LC §4062(a), there is a compelling argument that the Court meant any and all treatment requests that would be covered under §4062(a). To hold otherwise, would render §4062(b) null and void.

Further *Sandhagen* stands for the proposition that the plain language of the statute (i.e., §4062[a]) precludes an employer from objecting to treatment requests. However, there is no such preclusion under §4062(b). Indeed, the plain language of §4062(b) states that an employer *may* object to a request for spinal surgery, and there is no language *requiring* an employer to use utilization review. Further, there is nothing in the language of §4610 specifically addressing the spinal surgery issue. As such, it would appear that the employer could indeed object under §4062(b), send the request to utilization review, or do both simultaneously.

There is a potential trap inherent in using both procedures simultaneously in that there is a possibility that UR will certify the surgery, but the second opinion doctor will find it unnecessary. The natural argument is that the second opinion doctor’s opinion would be more substantial than the UR doctor’s opinion, as the second opinion doctor actually evaluated the employee. However, the courts have not yet addressed this issue, and I suspect that such a decision would be in the employee’s favor, as the workers’ compensation system is intended to be a benefits delivery system.

Therefore, although it may be permissible for the employer to use both utilization review and the second opinion process simultaneously, the utilization review decision will likely be received before the second opinion report, and if that report certifies the surgery, it would appear that the employer is required to authorize the surgery. As such, the better option would be to use the §4062(b) objection and obtain a report from a second opinion doctor after an actual examination.

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The Things We Did Last Quarter . . .

Quarterly Review

This newsletter is prepared for the benefit of our clients as a general review of recent developments in workers' compensation, subrogation, civil and labor law. These articles should not be construed as legal advice or opinion, and are not meant as a substitute for the advice of counsel in individual cases.

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Take a look at the great results that were obtained on behalf of our clients last quarter . . .

Julie Kennedy of the Novato office received a Take Nothing on a CIGA death case based on a statute of limitations defense. Applicant had an industrial injury in 1996 for which he received medical treatment and a 20% permanent disability with an open medical award. The applicant died in 2006, after which his widow filed an application for death benefits within one year of the date of death. However, the WCJ and the WCAB on Reconsideration found that the dependent death claim was not timely filed because it occurred more than 240 weeks from the date of injury.

Estimated Savings: \$170,000.

After two days of trial, **Rich Ellis of Fresno** received a Take Nothing in a case where applicant had initially denied to the HR manager that his hernia was related to his work and had obtained surgery through his private health insurance. The claim was filed later, coincidentally after learning that he was responsible for a 20% co-pay. The evidence showed that applicant had not received any medical treatment near the dates of the alleged injury, that he returned to his regular job after the surgery, and had subsequently been a member of a race pit crew where he had worked without problems.

Estimated Savings: \$92,017.

Shareholder Kathleen Roberts of San Jose obtained a Take Nothing in a rather unusual case. Applicant, a truck driver, suffered a stroke early one morning that, by his own admission, was non-industrial. However, applicant asserted that the stroke should be considered compensable alleging that the employer had denied medical care and threatened him with termination if he left the truck unattended. The WCJ found that applicant's failure to seek medical care on multiple occasions and his refusal to take an ambulance when offered by the employer was sufficient to relieve the employer of the responsibility for the effects of the stroke. **Estimated Savings: \$1.4 million.**

George Surmaitis of Novato obtained a Take Nothing for CIGA in which, after CIGA paid over \$90,000 in benefits, he was able to prove that the co-defendant constituted "other insurance" that relieved the guarantee fund of any liability. Applicant had worked for a temporary agency which the WCJ found to be a "special employer" under Insurance Code 1063.1. The co-defendant was unable to produce a copy of the contract which they purportedly relied upon, and the insurance policy was demonstrated to be void of an exclusionary clause as to temporary employees. Because of the co-defendants failure to counter CIGA's evidence, the WCJ found no such exclusionary clause. **Savings: \$90,000+.**

Joe Mendivel of Orange obtained a Take Nothing on a case in which applicant claimed that she fell down a flight of stairs and injured her back, neck, as well as both upper and lower extremities. In the Opinion on Decision, the WCJ stated "I do not find the applicant credible, injury not found." **Savings: \$62,963.41, of which \$17,571 was for medical liens.**

Neddy Liu of Los Angeles battled a medical treatment lien for over \$36,000 that consisted of "chiropractic treatment and occupational therapy". Our client paid for the first 24 chiropractic visits in the amount of \$1900, but objected to the balance based on the provisions of LC §4604.5 that limits chiropractic treatment. The WCJ awarded only about \$100 based on a bill review, agreeing with defendant that the 24 limit was applicable. On reconsideration, the lien claimant argued that another 24 visits should be awarded for "occupational therapy". Reconsideration was denied. **Savings: \$34,000.**

Cheryl Tobor of the Ventura office successfully asserted a credit on behalf of the employer in a 3rd party recovery. Applicant argued that the defendant was not entitled to the credit because she had paid medical bills out of her 3rd party settlement that should have been paid by the employer. The WCJ acknowledged that the applicant's recovery might have been larger had the employer paid the medical bills, but that it was irrelevant to defendant's legal entitlement to the credit. **Savings: \$21,715.**

Meanwhile, we follow up with last quarter's news of **Cheryl Tobor** as she announces the conviction and sentencing of an applicant for workers' compensation fraud that was won based on her investigative efforts. Applicant was sentenced to 180 days in jail and ordered to pay **\$98,801** in restitution to the employer.

Mike Ferguson of Sacramento prevailed in a highly disputed case concerning a compensable consequence that, had it been awarded, would have resulted in a 100% disability and potentially huge medical costs. Applicant had gained 150 pounds after a knee injury and suffered from extreme obesity, diabetes, sleep apnea and heart problems. Mike initially prevailed, but the WCJ vacated his order after applicant filed a petition for reconsideration requesting further development of the record. In his successful post-trial brief, Mike proved that the health conditions suffered by the applicant pre-dated the industrial injury.

Estimated Savings: Up to \$1 million.

NEW CASE NOTES

By Tim Kinsey, Managing Shareholder, Orange Office

Apportionment – An AME apportioned 25% of applicant’s disability after a hip replacement, the need for which was in part due to a non-industrial osteonecrosis. Although the necrosis was removed during the surgery, the AME testified that “but for” the osteonecrosis, the applicant would not have fractured her hip in her fall at work, and would not have required surgery. Reconsideration was denied. Citing the recent monumental California Supreme Court decision in *Brodie v. WCAB* (*this firm represented United Airlines in that successful appeal*), SB 899 apportionment of PD must include the percentage which was caused by other factors, which includes pathology, asymptomatic prior conditions, and retroactive prophylactic restrictions. *Malcolm v. CNA* (June 2, 2008) 36 CWCR 176. *Decision after Reconsideration.*

Off-Duty Officer Injury not AOE/COE – Applicant, a police sergeant, alleged that his off-duty vehicle accident in his city-assigned vehicle, which was equipped with a command and control unit, was compensable based on his belief that he was on call 24/7 and had his city-assigned cell phone turned on. This belief was based in part on a lieutenant who told him that he should “keep it with him”, which he understood to include personal use so that he could quickly respond to an emergency. The Court of Appeal agreed with the WCJ and the WCAB that the applicant did not establish the requisite nexus or causal relationship between his injuries and his employment in order to establish compensability. The applicant's belief that he was permitted to use the vehicle for personal use was “objectively unreasonable” as it was contrary to known departmental policy. *Harold Bickel v. WCAB* (June 5, 2008) 73 CCC 875.

Apportionment pursuant to Labor Code §4663(e) – Labor Code §§3212 – 3213.2 provide for presumptions of injury for certain safety officers. Eight of the sixteen sections do not contain non-attribution (non-apportionment) provisions. This correctional officer’s claim of presumptive heart injury with a CT date through 1/26/05 was found compensable without apportionment pursuant to Labor Code §3212.1 which did not contain a non-attribution provision. When the Legislature enacted the sweeping apportionment changes in §4663 per SB 899, arguably apportionment would be applicable to those sections without the non-attribution provisions. At issue was whether §4663(e), enacted by the Legislature effective 1/1/07 stating that it was “declaratory of existing law”, and that the apportionment provisions contained therein did not apply to any of the safety officer presumption statutes applied retroactively to this correctional officer’s claim. WCAB found that it did. The employer petitioned for review which was denied by both the Court of Appeal and the Supreme Court. Labor Code §4663(e) is retroactive, effectively enhancing all 16 statutory presumptions. *Department of Corrections and Rehabilitation v. WCAB* (November 19, 2008) *Supreme Court.*

APPELLATE CASE OF THE QUARTER: *Lane, MPNs and LC §4062*

By Joy Sidhwa and Kimberly Dyess, San Diego Office

Lane v. Big Lots Stores, et al., No. ADJ2708349 (October 13, 2008)

After the workers’ compensation judge ruled that the injuries were compensable and ordered the applicant, Melvin Lane, to treat within the employer’s Medical Provider Network (MPN), the applicant filed a petition for reconsideration, arguing that he could not be ordered to treat within the defendant’s MPN.

Self-procured treatment appears to be a growing trend among applicants, especially in the Los Angeles area, as a tactic to obtain higher permanent disability ratings and awards. Additionally, medical providers outside of MPNs continue to treat the claimants and bill defendant employers and carriers, despite the risk of having their liens legally denied and despite the clearly established ruling that claimants must pay out of pocket for care outside of networks.

The Workers’ Compensation Appeals Board recently issued a panel decision with regard to the liability of carriers and employers whereby the applicants self-procure medical treatment outside of the employers’ MPN, pursuant to Labor Code § 4605. The WCAB held that California employers are not liable for the cost of medical treatment billed by providers outside the MPN when applicants have been properly given notice of the existence of a network.

In particular, the WCAB stated, “Because defendant did not neglect or refuse to provide reasonable medical treatment through its MPN, applicant is liable for any medical treatment he chooses to self-procure pursuant to Section 4605 and he is not free to later assert that defendant is liable for the costs of any of that treatment. Nor may the treating physician seek payment from defendant for medical treatment that applicant chose to self-procure from the physician.”

This panel decision does not provide citable authority, but it does provide a strong argument for denying liens for self-procured treatment. In addition, the decision will help obviate the further need to dispute individual liens for out-of-network care following the applicant’s trial, thereby reducing the cost of litigating the liens.

(Continued on page 4)

Applicants' attorneys have reportedly downplayed the significance of the panel's decision, asserting that the WCAB's decision in *Lane* did not create new law but that it was merely in dicta to the *Bruce Knight* decision issued in connection with the defendants' MPN requirements. Rather, the panel's decision affirmed that an injured worker does not have to treat within the MPN and that medical reports from out-of-network providers are also admissible as substantial evidence.

Of course, applicants may choose to go outside the network, but on their own dime.

Ruling: California employers are not liable for the cost of medical treatment billed by providers outside the MPN when applicants have been properly given notice of the MPN.

THE REGULATORY CORNER: *EAMS & the Summary Rating Determination Process* By Peggy Sugarman, GLSR&T Training Director

The Electronic Adjudication Management System (EAMS) has all workers' compensation participants rethinking how they interact with the Division of Workers' Compensation. While the Court Administrator and AD regulations describe the rules by which we must abide, there are practical process questions for which we must devise our own strategies in order to ensure that cases flow smoothly. One such process that bears some discussion is the Summary Rating Process for unrepresented claims.

The Summary Rating Process was originally enacted in the early 1990s. The completed **Employee's Disability Questionnaire**, the **Request for Summary Rating** and the **QME report** were required to be sent to the DEU before the rating could be issued. This evolved into a more complex process that placed additional responsibility on the QME physician to send all of the documents directly to the DEU after completing the evaluation report.

This process remains in effect under the new EAMS regulations, CCR §10160. The challenge is that all of the forms have been converted to Optical Character Recognition format to be EAMS compatible. This includes the **Employee's Permanent Disability Questionnaire** [formerly DEU Form 100] and the **Request for Summary Rating Determination** [formerly DEU Form 101]. And, it isn't enough to send in the information using the new AD Forms. The process will require the package to be assembled using the new **Document Cover Sheet** and at least three **Document Separator Sheets** – four if you need to send in a wage statement. The documents also need to be submitted flat, clean, and without holes or other markings. This poses some challenges. First, the employee's questionnaire is unlikely to be in pristine condition when provided to the QME. Second, the QME is unlikely to be familiar with the new requirements and the idiosyncrasies of the EAMS system.

In order to speed up the process, claims administrators should consider the following new process if you are using the OCR filing method:

1. Prepare a standard cover letter to the QME that includes explicit instructions on how to prepare and assemble the package for DEU.
2. Include pre-prepared OCR document cover and separator sheets.
3. Request that the QME send in a clean photocopy of the Employee's Disability Questionnaire if it arrives folded or smudged so that the form will scan properly. (Assuming that you have properly downloaded the form from the DWC Website or have a compatible form, first-generation copies should not alter the bar code on the form.)

This way, all the QME will have to do is to place the completed report behind the correct separator sheet and, if necessary, make a photocopy of the questionnaire. By taking this extra step and incorporating it into your regular claims handling process, you could save valuable time in getting your cases concluded!

Quotes of the Quarter: *To VR or Not to VR, that is the Question . . .*

"The Division of Workers' Compensation (DWC) is reminding the workers' compensation community that the vocational rehabilitation program established under Labor Code section 139.5 will sunset on Jan. 1, 2009. Because the program will no longer be authorized, injured workers will not be entitled to vocational rehabilitation benefits or services after the program's sunset date. Any eligible injured employee who is interested in pursuing vocational rehabilitation benefits and services is encouraged to do so before the end of calendar year 2008." DWC Newsline No. 62-08 – October 27, 2008

VS.

"Therefore, it is the WCAB and the workers' compensation judges, not DWC, which will have the jurisdiction to determine: (1) Whether or not injured workers might be entitled to new or additional vocational rehabilitation services and benefits on or after Jan. 1, 2009; and, (2) Whether the WCAB can hear and determine vocational rehabilitation appeals filed on or after January 1, 2009 (Lab. Code, Section 5300(a), (b), & (f))." Neil Sullivan, the Deputy Commissioner of the WCAB – October 30, 2008.

LEGISLATIVE NEWS

By Peggy Sugarman, Training Director

In the final days of the 2008 legislative session, Governor Schwarzenegger vowed not to sign any bills until a state budget was passed, which led to an extraordinary number of vetoes. Here are some highlights on the fate of the bills we have been following:

WHAT GOT SIGNED:

SB 1271 (Cedillo) This bill extends the firefighter's cancer presumption to contracted firefighters employed by U.S. Department of Defense (DOD) installations that are the "functional equivalent" of federal employees and all fire and rescue services coordinators who work for the Office of Emergency Services.

SB 2091 (Fuentes). Originally designed to address pharmaceutical fees, this bill amends Labor Code §5307.2 originally enacted as part of SB 228. This bill added pharmaceuticals to the list of issues to be addressed in the "medical access" study required of the DWC, along with authority to increase pharmaceutical fees above 100% of MediCal rates if access problems were identified.

AB 2181 (Ruskin). Originally designed to provide the DIR with funds to create materials to assist and educate employers on RTW and FEHA issues, the bill was amended to require that the Employer's First Report of Injury (FROI) be submitted to the DWC in electronic form pursuant to rules adopted by the administrative director. This change basically switches the oversight from the Division of Labor Statistics to the DWC, consistent with the electronic reporting to the Workers' Compensation Information System.

AB 1389 (Budget Committee): This bill imposes \$18.9 million in new surcharges to employers to fund occupational health and safety laws, and extends the workplace modification reimbursement program at the DWC until 1/1/10.

AB 2754 (Bass): Adds MRSA (Methicillin-resistant staphylococcus aureus) to the list of presumptions for public safety employees, and continues the presumption through 90 days after the termination of public service.

WHAT FAILED:

SB 1189 (Cedillo) would have revised the process for issuing supplemental job retraining benefits by coordinating the "trigger" dates for RTW offers that are currently different for the voucher and the 15 % ± PD payment. The bill was held in Appropriations and did not survive. The DWC plans to continue discussions with stakeholders on how to improve return-to-work provisions.

AB 2987 (Benoit) also tackled the issue of supplemental job displacement benefits and has been amended as recently as August 4, 2008 to change the "trigger" date for the job offer to 60 days after receipt of a P & S report from the PTP, AME or QME.

SB 1717 (Perata) would have increased permanent disability benefits over three years beginning with dates of injury on or after 1/1/09.

AB 2081 (Coto) After four amendments, this bill addressed the issue of coverage for shareholders of a firm and would have prevented payments to utilization review companies on certain bases.

SB 1115 (Midgen) would have prohibited apportionment to factors that were considered to be discriminatory in nature.

AB 2989 (Lieber) would have required that physicians performing utilization review be licensed to practice medicine in California.

NEED TRAINING? GLSR&T offers:

- ADA/FEHA and WC Claims
- Apportionment
- EAMS
- Medical Provider Networks
- MRSA Claims
- Penalties
- Return-to-Work
- Subrogation
- Sleep Disorders and other WPI "Add-Ons"
- Utilization Review

IN THE NEXT ISSUE

SUBROGATION: A PRIMER, UPDATE AND STRATEGIES

ANNOUNCEMENTS

Jeff Stander welcomes **Teresa Elizabeth Bissner** to his legal team in Los Angeles. Teresa completed her Bachelor of Science degree from UC San Diego in religious studies before proceeding to California Western School of Law where, in addition to her Juris Doctorate, she received the Anson Levitan Award in 2003 and the William H. Wiley Award (Legal Aid Society) in 2004. She was also a recipient of the Creating Problem Solving Merit Scholarship. She has experience in corporate contract management and is excited to join the GLSR&T Team!

Joanne Thomas welcomes **Kevin Nguyen** to the Riverside legal team. Kevin is a graduate of the University of California, Irvine with a degree in Political Science and an emphasis in public law. He received his Juris Doctorate from Whittier School of Law. Kevin's studies took him to China for a summer where he completed coursework at the Nanjing University School of Law. He is fluent in the Vietnamese language, which will be a tremendous asset to the firm and to our clients.

GLSR&T IN THE COMMUNITY! Did you know . . .

Kimberly Dyess took the plunge into the E-Forms Trial after the DWC asked system participants to help it perfect the new Electronic Adjudication Management System (EAMS). Always looking to innovation, our San Diego office agreed to be one of the first to participate in a system trial. At first, the intricacies of e-filing in EAMS were time consuming and arduous for support staff as the inevitable "bugs" are worked out of the system. It has been occasionally confusing to attorneys, mostly because it has been clearly overwhelming for the local Board staff and judges, some of whom have not been on the same page as those in charge of EAMS.

Although the road to EAMS implementation was a bit bumpy, significant progress has been made. As our excellent support staff performs more e-filing and the attorneys confirm that the documents are being received and filtered through the judicial system successfully, our confidence is growing in the lasting ability of EAMS to greatly assist with more expeditious resolution of cases and issues within our workers' compensation system. The DWC and the EAMS Help Desk in Sacramento are also learning the system better and are continuing to assist members of the trial as issues arise on a daily basis. These efforts are both challenging and rewarding and further the close teamwork environment we share in our firm and our community. While there may still be many bumps ahead, our firm has learned and continues to learn a great deal of valuable information about EAMS and will be far ahead of the curve when the DWC mandates that all members of the workers' compensation community use EAMS exclusively.

Training continues to be a prominent part of our services to our clients. GLSR&T's attorneys have been busy providing valuable programs that include such subjects as how to spot and handle 3rd party subrogation claims, subjective "add-ons" to permanent impairment ratings such as sleep disorders or pain, or our popular program on EAMS given by our training director, Peggy Sugarman. For more information on the many programs that we offer, send an email to: psugarman@grancell-law.com.

Chico branch manager **Jerry Rempel** joined a panel of experts at the Association of Workers' Compensation Professionals' annual conference in Sacramento in October dealing with the challenges in the QME process. The panel included WCAB Commissioners Ronnie Caplane and Al Moresi, DWC Chief Counsel Destie Overpeck, DWC Medical Director Anne Searcy, Todd McFarren, the president of the California Applicants' Attorneys Association and was moderated by Peggy Sugarman. The presentation included an overview of the proposed QME regulations and a lively, interactive discussion that centered on common scenarios.

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