Significant Decisions

of 2002 in

California Workers' Compensation

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OUTLINE FOR FALL 2002
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I Jurisdiction

1. *Fotiades v. Hi-Tech Collision & Painting Sevices, Inc.* (2002) (Not Published)
67 CCC 255.

Plaintiff worked for a chain of auto body shops when his genitalia were photographed while he was urinating in the men's restroom. The photograph was taken by a co-worker and circulated among other co-workers who openly laughed about its contents. Plaintiff sued in civil court and was awarded damages, and Defendant argued on Appeal that workers' compensation was his exclusive remedy.

In determining that the facts of this case fell outside the scope of the compensation bargain, the exclusivity rule does not apply to conduct having a questionable relationship to the employment. The court distinguished a few key cases in the arena of exclusivity such as *Cole v. Fair Oaks Fire Protection Dist*., (1987) 43 Cal. 3d 148 where plaintiff claimed he was harassed because of his participation in a union. The court in *Cole* determined that this was indeed a part of the compensation bargain because the employer's conduct was deemed to be within the normal range of behavior for an employer; "a normal part of the employment relationship". In *Cole*, Plaintiff's claim for intentional infliction of emotional distress was barred by the exclusive remedy rule. However, the court also cited conduct that clearly fell outside the compensation bargain like sexual harassment, discrimination based on race or age, or wrongful termination in violation of public policy.

Applying the test from *Hart v. National Mortgage & Land Co.* (1987) 189 Cal. App. 3d 1420, whether the employer's action was a normal part of the employment relationship or whether the acts were incidents of the employment relationship, the court determined that the exclusive remedy did not bar Applicant's civil cause of action. In the words of the court, "By no stretch of the imagination can we view defendants' conduct in this case as 'normal part of the employment relationship.' When an agent of the employer breaks into the bathroom where an employee is urinating, photographs him, circulates the photograph to his coworkers, ridicules his penis and encourages others to do so, the employer has stepped outside its proper role."

The remaining issues addressed by the court did not involve workers' compensation issues.

2. *Palestini v. General Dynamics Corp.* (2002) 67 CCC 754.

The plaintiff was employed as a plastics fabricator from 1982 to 1994 during which time he was exposed to solvents and other chemicals that could be absorbed through the skin and cause cancer in various internal organs. He was instructed to wear gloves, but they would disintegrate and provide little protection. He developed skin rashes and discoloration and eventually contracted testicular and other cancers. He sued the two employers where he was exposed, seeking damages. He also alleged that both employers fraudulently concealed from him that his skin problems were a precursor to cancer. He alleged that he told his supervisors of the skin problems, and they replied that the chemicals were safe to use. Their reply deprived him of the opportunity to take proper precautions or to seek other employment. He alleged injuries including the cancer and chronic medical problems due to the cancer and the treatment. His wife sought loss of consortium damages.

The Superior Court judge dismissed the lawsuit on the ground that Workers' Compensation provided the exclusive remedy. The judge found that there was no exception to WCAB exclusivity and that the plaintiff had failed to plead, and could not plead or prove that the employers had actual prior knowledge of his injuries or that they were aware of an injury before the worker discovered it. The plaintiff and his wife appealed.

The DCA reversed, allowing the plaintiff and his wife to proceed noting that an employee may bring an action for damages at law where the injury is aggravated by the employer's fraudulent concealment of the existence of the injury and its connection with the employment.

The Court here followed *Foster v. Xerox Corp.* (1985) 40 C 3d 306 where the Supreme Court rejected an employer's contention that the Labor Code §3602(b)(2) exception to exclusivity required a showing that the employer made affirmative misrepresentations. The *Foster* court ruled that to overcome a demurrer it was sufficient that the complaint allege in general terms that the employer knew of the employee's disease and that the injuries reported by the worker to the employer were aggravated by continued exposure to a harmful substance while at work. Per *Foster,* the plaintiff states a cause of action by pleading facts in general terms, which, if found true, establish the existence of three essential elements:

1. The employer knew that the plaintiff suffered a work related injury.
2. The employer concealed that knowledge from the plaintiff.
3. The injury was aggravated as a result of such concealment

Further, CCP §452 requires that the complaint must be liberally construed so as to achieve substantial justice.

The Court here reviewed the complaint and determined that the pleadings tended to show in general terms the three essential elements set forth in *Foster*. Therefore, the Court reversed the dismissal of the plaintiff's complaint and remanded that matter to Superior Court for further proceedings.

3. *Ruiz v. Cabrera* (2002) 67CCC 628.

The applicant was an agricultural worker employed by a registered farm labor contractor when he was injured in a motor vehicle accident. A co-worker, who was driving, ran a stop sign. The injured worker sued the contractor for personal injury damages, arguing that the contractor was liable for the co-worker's negligent driving. The contractor responded that Workers' Compensation provided the exclusive remedy. The Superior Court judge granted summary judgment in the contractor's favor, holding that the contractor was the worker's employer and the injury arose out of and occurred in the course of employment. The court held that the contractor was immune from damages liability under L. C. § 3602. The injured worker appealed.

The DCA affirmed the judgement against the worker, rejecting the worker's claim that certain sections of the California Farm Labor Contractor Act (FLCA) creates an exception to the immunity provided by L. C. § 3602. The Court held that employer immunity under L. C. § 3602 does not conflict with FLCA § 1695.7(c)(4) which provides that an aggrieved worker may bring a civil action for FLCA violations. Nor is immunity negated by FLCA §1697(b) which allows an aggrieved employee to sue for injunctive relieve or damages, or both for certain violations of the FLCA. The Court pointed out that the focus of the FLCA is to preserve the financial integrity of the farm employment relationship by insuring the payment of wages, assuring availability of promised work and prohibiting unfair charges against employees. This is reflected in the legislation which characterizes the employee as being aggrieved rather than identifying the employee as being injured.

The Court also concluded that the availability of the exclusivity defense to a farm labor contractor is not affected by FLCA § 1695(a)(6) which requires the contractor to maintain insurance against liability for damage to persons or property arising out of the contractor's operation or ownership of a vehicle for the transportation of individuals in connection with his operations. Such liability insurance appears to provide little or no benefit to the contractor who is already protected from liability by L. C. § 3602, but it cannot be said that applying L. C. § 3602 would render the FLCA insurance provisions meaningless or absurd.

The Court here says the holdings in City of Moorpark v. Superior Court (Dillon) (1998) 63 CCC 944 and Shoemaker v. Myers (1990) 55 CCC 494 do not aid the worker's claim here. City of Moorpark held that a worker could pursue damages for disability discrimination that was not compensable under Workers' Compensation even if the disability arose from an on-the-job-injury. Shoemaker held that a worker could seek damages for an injury caused by employer's conduct that was outside the normal employment relationship. Here the worker's injury is compensable, and the employer's conduct was within the normal employment relationship.

4. *White v. Department of Transportation/State of California* (2002) 67 CCC 130 (Not Published).

A disgruntled former employee returned to the workplace and killed three former co-workers in a trailer at the Batavia yard, a Caltrans facility, and one former co-worker in a parking lot adjacent to the Batavia yard. The trailer had three doors, but two were

locked in violation of a provision of the California building code, and the third was used by the assailant to gain entry. Plaintiff dependents of deceased employees contended that the exclusive remedy doctrine did not apply because Caltrans failed to provide a safe workplace. The trial court held the actions were barred by the exclusive remedy doctrine; the Court of Appeal agreed, holding that to escape the exclusive remedy doctrine plaintiffs must plead and prove that the employer "acted deliberately with the specific intent to injure…" Here the party with specific intent was the dismissed former employee.

5. *Wright v. Beverly Fabrics* (2002) 67 CCC 51.

Paula Wright, an employee of Beverly Fabrics, came into work on her day off to sign a condolence card and donate money for two fellow employees who had lost family members. Ms. Wright was in the back of the store talking to two employees that were on duty. Unfortunately, while there, she injured her back as she helped hold up a collapsing shelf containing store merchandise.

Ms. Wright was standing near the shelf when it started to fall and instinctively moved to hold it up. It took some time before the shelf could be cleared of merchandise, and customers were kept from the area. She would not have been allowed to assist if she had not been an employee. Further, she would have been asked to assist, if she had not volunteered, despite the fact it was her day off.

Ms. Wright filed suit against her employer for personal injury damages alleging negligence. Beverly Fabrics answered the complaint, asserting as an affirmative defense that Ms. Wright's sole remedy was workers' compensation benefits.

The trial court held, as a matter of law, that applicant was not in the course of her employment at the time of her injury. The matter went to trial and a jury found negligence and awarded Ms. Wright $512,905.13. Defendant appealed.

On appeal defendant contended that Ms. Wright was performing a service growing out of and incidental to her employment and was acting within the course of her employment. Ms. Wright argued that the conditions of employment set forth in L.C. §3600 had not been met because the injury arose out of the voluntary participation in an off-duty social activity not constituting part of her work-related duties.

The requirement of L. C. §3600 is twofold. The concept of "course of employment" refers to those reasonable things which his contract with his employer expressly or impliedly permits him to do. On the other hand, "arise out of" refers to a requirement that the injury must be linked in some causal fashion to his employment. *LaTouette v. WCAB*, (1998) 63 CCC 253.

As the court noted, the cases have held that injuries sustained while an employee is performing tasks within his employment contract, but outside normal work hours are within the "course of employment." As explained in Scott v. Pacific Coast Borax Co., (1956) 21 CCC 138: "…a workman who sustains injury while rendering reasonably needed assistance to a fellow workman in furtherance of the employer's business is

considered to have suffered an injury arising out of and in the course of his employment when the act done is within the reasonable contemplation of what the employee may do in the service of his employer."

The test for what constitutes a reasonable expectancy of employment is set forth in *Ezzy v. WCAB* (1983) 48 CCC 611. An activity is deemed a reasonable expectancy of employment if the employee subjectively believed that his participation was expected by the employer, and that belief is objectively reasonable.

Applying the test here, the court found that Ms. Wright's activities were within the course and scope of her employment. The judgement was reversed.

II Employment

1. *Land v. WCAB* (2002) 67 CCC 1109 (unpublished).

Applicant was a full-time student at Cal Poly. She enrolled in an elective course in animal husbandry. The class provided practical, hands-on experience in commercial cattle breeding. The course was administered by Cal Poly Foundation, a non-profit corporation. The animals, tools and equipment were provided by the Foundation. Applicant paid tuition to attend the class and received class credits. The class was supervised by Cal Poly teachers.

The students signed an agreement as a condition of being accepted into the class. The agreement provided that students logging at least 70 hours during the year would be eligible to receive a prorated portion of the profits from the sale of the cattle at the end of the year, up to a limit of $1000.00. The agreement also provided for a maximum of $15,000.00 in medical insurance as a result of any accident occurring during class.

Each student set his or her own hours. Applicant spent an average of 6 to 10 hours per week engaged in the activities of caring for the cattle. At the end of the class applicant received $780.00 as her share of the net profits.

Applicant sustained an injury when she lost control of an ATV owned by the Foundation. Thereafter, she filed a claim for workers' compensation benefits.

At trial, the WCJ concluded applicant was not entitled to workers' compensation benefits because she was not paid wages and the purpose of the class was to provide experience, not monetary gain.

The WCAB denied reconsideration. The writ was originally denied by the court of appeal, but was granted upon direction from the Supreme Court. After consideration of the case on the merits, the writ was denied.

L. C. §3351 defines a covered employee as "every person in the service of an employer under any appointment or contract of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed…." L. C. §3357 augments this

definition, stating: " Any person rendering service for another, other than as an independent contractor, or unless expressly excluded herein, is presumed to be an employee."

In deciding that applicant was not an employee, the court had to distinguish this case from ones that had found nursing students were employees while interning at local hospitals. The court noted that the nursing students were engaged in activities normally done by paid workers.

The Board reasoned, and the appeals court agreed, that applicant here was different because she was involved in one of several classes available to complete her chosen field of education. The nurses were required to take the internship. The court further notes that applicant was not working with paid workers. Applicant was not working in an established business or institution.

Finally, the court noted that applicant was not rendering service to the University, but rather applicant was "consuming" the educational product of the University.

2. *Rojas v. Ay*ala (Board Panel Decision) (2002) 30 CWCR 95.

Applicant was employed as a tree cutter by Pedro Ayala, doing business as Ayala Tree Service. In addition to cutting and removing trees, applicant drove the employer's truck, used clippers and motorized saws and removed tree trunks. He was paid $50 a day and was supervised by Ayala. Ayala had neither a contractor's license nor workers' compensation insurance.

In December 1995, Ayala contracted with homeowners to remove large trees from their residential property. Applicant worked on that job a total of 38 hours before he injured his knee on December 9, 1995.

The applicant filed an application alleging a knee injury and that he was employed by both the homeowner and Ayala. The WCJ, after hearing, found the applicant's sole employer was Ayala. The judge, in her Opinion on Decision, reasoned that because Business and Professions Code §7026.1(c) requires a contractors' license for work performed, neither applicant, nor Ayala could be independent contractors. Anyone doing work for which a license is required pursuant to Business and Professions Code §7000 et seq. must have, under L. C. § 2750.5, a valid contractor's license as a condition of having independent contractor status.

Neither applicant, nor Ayala, the WCJ continued, could be employees of the homeowners, however, because neither had worked for them for 52 hours during the 90 days before the injury. L. C. § 3352(h) excludes from the definition of employee any residential worker employed by the alleged employer for fewer than 52 hours during the 90 calendar days immediately preceding the injury. Neither had worked on the property for 52 hours before the injury.

The Uninsured Employers Fund sought reconsideration of the finding that Ayala was the employer. It contended that, under L. C. § 2750.5, an unlicensed and uninsured contractor cannot be an employer, therefore Ayala was an employee of the homeowner; and the WCJ's finding was contrary to public policy.

The WCAB concluded that the WCJ had reached the correct result. The panel first indicated that Business and Professions Code § 7026.1(c) requires a contractor's license for anyone who performs tree removal, tree pruning or tree stump removal or engages in tree or limb cabling or guying. A contractor's license is not required by nurserymen who perform incidental pruning of trees or guying of planted trees in the normal course of their routine work, nor by gardeners who perform incidental pruning of trees less than 15 feet high in the normal course of their routine work. The trees on which the applicant was working were stipulated to be taller than 15 feet. Under L. C. §2750.5, therefore, applicant could not have been an independent contractor because neither he, nor Ayala had the required license.

Turning, then, to the question of whether Ayala was an employee of the homeowners, the panel quoted L. C. § 3351(d) to the effect that, except as provided in subdivision (h) of L. C. §3352, the term "employee" includes any person employed by the owner or occupant of a residential dwelling whose duties are incidental to the ownership, maintenance or use of the dwelling and whose duties are personal and not in the course of the trade, business, profession or occupation of the owner or occupant. L. C. § 3352(h) in turn excludes any such employee who was employed by the owner or occupant for fewer than 52 hours during the 90 calendar days immediately preceding the injury or who earned less than $100 from the employer during the period. Therefore, neither applicant, nor Ayala was an employee of the homeowner.

The panel conceded that *State Fund v. WCAB (Meier),* 50 CCC 562, and *Blew v. Horner,* 14 CWCR 230, 51 CCC 615, establish the principle that where a homeowner hires an unlicensed contractor and that contractor hires employees, both the unlicensed contractor and those employees are employees of the ultimate hirer, the homeowner, but distinguished the case on the ground that they dealt with the question of whether the homeowner could use the employment status as a defense in a civil action. Here, employment by the homeowner was excluded by L. C. § 3352(h).

Finally, the panel relied on *Rinaldi v. WCAB (Hamilton),*55 CCC 256, to support the finding that the applicant was Ayala's employee. There, a roofer, who was hired by an unlicensed contractor and injured before he worked 52 hours on the homeowner's roof, was found to be the employee of an unlicensed contractor and entitled to benefits from the UEF.

After discussing *Rosas v. Dishong,* 63 CCC 1376, which indicated that an employee by reason of L. C. § 2750.5, but not subject to the compensation provisions of Division 4 of the Labor Code because of L. C. § 3352(h), could bring a civil action against the employer, the panel concluded that as between Ayala, as the alleged contractor, and the homeowner, Ayala would be an employee under L. C. § 2750.5. However, because Ayala has no claim against the homeowner and does not meet the hour requirement of L. C. § 3352(h), any more than applicant meets the 52-hour requirement under Division 4,

Ayala cannot be an employee. Therefore, the court is not required to refer to the definition of Ayala as an employee as set forth in L. C. § 2750.5.

Therefore, Ayala is the employer of the applicant and UEF becomes liable in the case for the compensation under the Workers' Compensation Act.

3. *Safeco Insurance Companies v. WCAB (Allison)* (2002) 67 CCC 1429 (not certified for publication).

The Applicant filed a claim for cumulative trauma through June 28, 1996, naming insurers Safeco and Superior Pacific as defendants.

Following a trial, the WCJ awarded benefits, holding both carriers jointly and severally liable and ordering Safeco to administer the Award, since Superior had become insolvent. Safeco sought reconsideration, arguing that Applicant did not work for the employer during the period of its coverage, within one year of the ending date of injury. The Petition for Reconsideration was denied by the Appeals Board. The Court of Appeal, in a *per curiam* opinion, noted that the date of a cumulative trauma injury is the date on which the employee first suffered disability and knew, or should have known, that his disability was caused by his employment.

Under L.C. §5500.5, benefits will be awarded from the carriers that insured the employer during the one year prior to the last date of injury or last date of work having injurious exposure. Court went onto state that the WCAB determined reasonably that the continuous trauma injury occurred on June 28, 1996, when the Applicant filed her disability claim.

The Court said that no evidence indicates that the Applicant worked while Safeco insured the employer during the one year liability period. The Applicant's testimony and the report of the agreed medical examiner both indicate otherwise. Workers' compensation liability may not be imposed without a causal connection between the employment and the injury. Lacking any evidence to support its determination of a causal connection, the WCAB erred in imposing liability against Safeco. Absent any evidence that Applicant worked during Safeco's coverage, it would be futile to require certification of the record from the WCAB.

The writ was granted, and the Board order denying reconsideration was annulled, and the case was remanded for further proceedings.

4. *Smith (Stephen, J.) v. W.C.A.B. (Lee)* (2002) 67 CCC 107.

Where a contractor licensed by the State Contractor's Licensing Board (SCLB) entered a contract to paint, and where his license was suspended but the SCLB did not issue notices of suspension, the building owner was not liable under the *Meier* doctrine for workers' compensation benefits to the contractor's injured employee.

III Insurance Coverage

1. *California Insurance Guarantee Association v. W.C.A.B. (Harris)* (2002) (writ denied) 67 CCC 171.

L. C. §5814 penalties are "covered claims" within the meaning of Insurance Code §1063.1, and CIGA is therefore liable for payment of §5814 penalties. Applicant was injured on 4/21/99 while employed by Harris and Ruth Painting. Harris and Ruth Painting were then insured as to workers' compensation liability by HIH America. On May 8, 2001, HIH America was declared insolvent and placed in liquidation. On July 27, 2001, an amended Award based on stipulations issued containing a finding of permanent partial disability and a finding that HIH America had unreasonably delayed payment of permanent disability indemnity advances. The amended Award issued against the employer only. CIGA sought reconsideration, contending its status was comparable to the UEF, and that under *DuBois* it should be exempt from liability for penalties; and contending that penalties are not "covered claims." The Board, citing *Carver v. W.C.A.B.* (1990, Court of Appeal) 55 CCC 36, held that §5814 penalties are not punitive damages and are covered claims for which CIGA has liability. Where PPD indemnity was payable by the employer, the insurer, and by CIGA, and where payment was unreasonably delayed by the insurer, CIGA is liable for §5814 penalty. The Board amended the award to include Harris and Ruth Painting, HIH Insurance in liquidation, and CIGA (administered by Intercare Insurance Services). Defendant's petition for writ of review was denied.

2. *California Insurance Guarantee Association v. W.C.A..B. (Novak)* (2002) (writ denied) 67 CCC 315.

Applicant sustained a head injury on 12/31/97 on which date HIH America insured his employer. Applicant, claiming delayed benefit payments, filed a Petition for Penalties on 1/25/01. On 5/8/01 HIH America became insolvent, and the Superior Court issued an Order Appointing Liquidator and Restraining Orders, effectively inserting the California Insurance Guarantee Association (CIGA) as a party in interest. On 6/14/01 the WCALJ issued a decision in which penalties were awarded against HIH America. CIGA filed a petition for reconsideration on 7/13/01 claiming that the penalty award did not amount to a “covered claim” for which CIGA has liability. CIGA also claimed that the petition for reconsideration was timely.

Due to the 45 day stay afforded CIGA by operation of law, the WCALJ concluded that the petition for reconsideration was timely filed. On the issue of whether acts or omissions causing penalty under Labor Code §§ 4650(d) and 5814 occurring before CIGA’s involvement in a claim could amount to a “covered claim” for which CIGA would have responsibility, the court followed the reasoning of *Carver v. WCAB* (1990) 55 CCC 36. Since penalties are increased compensation and not punitive damages, CIGA is not exempt from paying them. Further, CIGA attempted to analogize to the facts in *DuBois v. WCAB* (1993) 58 CCC 286, where the Uninsured Employers Fund (UEF) was statutorily insulated from penalties arising under Labor Code § 5814. This

analogy was found to be inappropriate since CIGA is not similarly insulated from penalties by statute.

The subsequent writ of review before the Supreme Court was denied.

3. *Coldiron v. Compuware Corp.*, (2002) (WCAB En Banc) 67 CCC 289.

Where an employer's liability for workers' compensation benefits is adjusted by a third-party administrator, the administrator must disclose to the Workers' Compensation Appeals Board, to the other parties in any proceedings in which it is a party, and to its own counsel the identity of its client, whether a self-insured employer or insurance carrier. If the client is an insurance carrier, the administrator must disclose whether the policy includes a "high self-insured retention," a large deductible, or any other provision that affects the identity of the entity actually liable for the payment of compensation. Failure of the administrator to disclose the identity of its client may subject it to sanctions pursuant to Labor Code §5813.

4. *Coldiron v. Compuware Corporation, CIGA for Reliance Insurance in Liquidation*, (2002) (WCAB En Banc) 67 CCC 1466.

Applicant sustained an admitted injury to her neck and back on January 13, 1995. In a prior En Banc decision in this case it was noted that defendant had appeared at Mandatory Settlement Conference on March 2,1999, and entered stipulations providing that Compuware was permissibly self-insured. On August 31, 1999, Findings and Award of various benefits, including $28,203 in permanent partial disability indemnity, issued against Compuware, permissibly self insured. Defendant sought reconsideration asserting for the first time that Compuware had been insured as to workers' compensation liability in January 1995 by Reliance National Insurance Company.

In the initial En Banc decision, the Board held that a third party administrator must disclose to the Workers' Compensation Appeals Board, its counsel, and other parties in any proceeding, the identity of its client, and whether it is acting on behalf of an insurer or self-insured employer. It also must disclose any limitations or conditions, such as a high self-insured retention, large deductible, or any other provision that affects the identity of the entity actually liable for the payment of compensation.

At a Commissioner's Conference, an offer of proof was submitted concerning Reliance's coverage of Compuware, and representations were made that the adjusting agency had in fact not notified its counsel or the Board of the insurance coverage until after the August 31, 1999, Findings and Award. Thereafter, the Board reviewed the coverage documents submitted and determined that they did not show conclusively that Compuware secured payment of all compensation through Reliance National Insurance Company, but did warrant joining of CIGA.

The Board declined to impose sanctions on Gallagher Bassett because the case was one of first impression. But the Board reiterated that a third party administrator has an obligation to promptly determine and disclose the identity of its client and, if an insurer, any limitations or conditions, such as a high self-insured retention, large deductible, or

any other provision that affects the identity of the entity actually liable for the payment of compensation.

5. *Hershman v. James Eisenberg Medical Group,* (2002) (WCAB En Banc) 67 CCC 808.

On December 17, 1998, a WCJ found that, as a result of an industrial injury, the applicant had a period of temporary disability, suffered permanent disability and need for medical treatment. The WCJ also found that compensation had been unreasonably delayed. The award was made against the employer's compensation carrier, California Compensation Insurance Company. A petition for L.C. § 5814 penalties was filed by the applicant claiming that payment of the December 17, 1998, award had been unreasonably delayed. Before the petition was heard the Superior Court, on December 26, 2000, found defendant to be insolvent and directed the insurance commissioner to liquidate it and wind up its business. Pursuant to Insurance Code §1063.2(a), CIGA assumed liability for administering and paying the claim. The matter was then set for hearing on the petition for penalties. At that hearing, CIGA argued that it had no liability for L.C. § 5814 penalties for pre-liquidation delays of the insolvent insurer. On August 7, 2001, the WCJ served Interim Findings and Award to the effect that CIGA could be liable for increased compensation under L.C. §5814 resulting from those delays. CIGA petitioned for reconsideration, or, in the alternative, for removal, contending that (1), because Insurance Code §1063.1(c)(8) excludes punitive or exemplary damages from the definition of covered claims, it was not liable for L.C. § 5814 penalties; (2), based on public policy, it should not be liable for penalties; and (3), because of its limited ability to generate funds and the inordinate rate by which its available funds were being consumed by many recent insolvencies, it should be insulated from liability for penalties to conserve its funds and enable it to continue providing normal benefits to injured workers.

A panel granted reconsideration. Because of the importance of the legal issue raised and to secure uniformity of decision, the chairman, and a majority of the commissioners, reassigned the case to the Board as a whole for decision.

The Board, after reviewing the case law and statutes, affirmed the WCJ's decision. The Board unanimously concluded that L.C. § 5814 penalties, based on an insolvent insurer's pre-liquidation delays, are covered claims within the meaning of Insurance Code §1063.1, et seq, and CIGA's public policy argument does not absolve it from liability. The Board indicated that § 1063.1(c)(1) defines covered claims as the obligations of an insolvent insured imposed by law in its contract of insurance to provide benefits under the California Workers' Compensation law. The definition is limited by specific statutory exceptions in §1063.1 (c)(1 through 12) and §1063.2. The Board explained that the phrase "workers' compensation benefits" under the Workers' Compensation law of this state is broad enough to include L.C. §5814 penalties. L.C. § 3207 defines compensation as including every benefit conferred by Division 4, where L.C. §5814 is found. Although informally referred to as a penalty, the 10 percent increase provided by L.C. §5814 is actually an increase in the compensation awarded to an injured employee.

The Board, having concluded that L.C. § 5814 penalties are compensation and fall within Insurance Code §1063.1(c)(1), which defines covered claims, the Board turned to Petitioner's assertion that they were excluded by the §1063.1(c)(a) provision that covered claims do not include any amount awarded if it is punitive or exemplary damages. The Board stated that in *Carver v. WCAB*,55 CCC 36, the Court specifically said that L.C. § 5814 increases in compensation cannot be properly characterized as punitive damages. The Board indicated it is correct, as argued by CIGA, that the discussion of the punitive damages exclusion in *Carver* was dictum. The Board stated that although dictum may not be controlling precedent, it can be considered persuasive precedent if it is amply supported by sound reasoning and other precedent. The Board found support for the *Carver* dictum in the well-settled rule that a L.C. § 5814 award is an increase in, and not a separate class of benefit from the compensation to which it applies. The Board went on to state that L.C. § 3209 moreover expressly defines damages as the recovery allowed in an action at law as contrasted with compensation. A L.C. § 5814 award, therefore, would not be damages because the WCAB can only award compensation. Finally, punitive damages are generally not limited in amount. L.C. § 5814 awards, on the other hand, are limited to 10 percent of the class of the benefit delayed.

Turning to the final argument made by CIGA, based on public policy, the Board found a fundamental flaw in its assertion that because the Uninsured Employers Fund and the self-insured's security fund were not liable for unreasonable delays, CIGA should not be liable. The Labor Code expressly exempts UEF and SIF from L.C. § 5814 awards. No similar statute exempts CIGA from liability.

Similarly unpersuasive to the Board was Petitioner's argument that because of its limited ability to generate funds to pay covered claims and the inordinate rate by which its available funds are being consumed by the recent insolvencies of workers' compensation insurers, it should be insulated from liability for L.C. § 5814 awards in order to conserve its funds and enable it to continue providing a limited form of protection to injured workers. The Board indicated this argument was rejected in *Carver* (supra).

As a supplement to its discussion, the Board observed that the WCJ said in her decision that CIGA should be held liable for interest, but she did not actually award any. The Board concluded that interest is no different from the underlying benefit to which it attaches. It is compensation for which CIGA is liable, but Insurance Code §1063.2(h) provides that interest secured before the appointment of a liquidator is not a covered claim. The WCJ may not, therefore, hold CIGA liable for any interest that accrued before the liquidator was appointed.

The matter was returned to the WCAB for further proceedings consistent with the Court's opinion.

6. *Karaiskos v. Metagenics, Inc/Viveros v. North Ranch Country Club* (2002) (WCAB En Banc) 67 CCC 900.

The applicant's claim was settled by Compromise & Release with defendant leaving the EDD lien to be litigated. After the carrier's insolvency, the WCJ made a tentative finding

that CIGA may be liable for EDD's lien, and CIGA sought reconsideration. A panel reversed the WCJ and found that EDD's lien was an obligation to the State, precluded by Insurance Code §1063.1(c)(4). Then EDD sought reconsideration of the Board's decision.

In *Viveros* the WCJ awarded compensation to the applicant after trial, but disallowed EDD's lien pursuant to Insurance Code § 1063.1(c)(4). EDD petitioned for reconsideration.

The Board granted reconsideration in both cases to further study the record concerning CIGA's potential liability for EDD liens. Subsequently, because of the importance of the legal issue presented, the matter was assigned to the whole Board for an en banc decision.

The Board, en banc, concluded that the EDD liens for UCD benefits are not obligations to the State and, therefore, are covered claims under Insurance Code § 1063.1(c)(4) for which CIGA may be liable. When the Board finds CIGA or its insolvent carrier liable for compensation against which an EDD lien may be allowed, whether by Findings & Award, Stipulations & Award, or Order Approving Compromise & Release, the EDD lien is an obligation to the injured worker and not to the State. Therefore Insurance Code § 1063.1(c)(4) does not exclude EDD's lien from the definition of covered claims.

In *Carver v. WCAB*, 55CCC 36, the Court of Appeals stated that CIGA was created in 1969 to protect policyholders and claimants under policies of insurance issued by insurers who later become insolvent. It provides insolvency insurance to protect the public from insurers who cannot pay claims by requiring mandatory membership of insureds, primarily in the workers' compensation, automobile, and other property and casualty lines of insurance. While CIGA is in the business of protecting policyholders, claimants, and the public from the effects of insolvent insurers, it is limited to the payment of covered claims as defined in Insurance Code § 1063.1. Insurance Code § 103.61(c)(1)(vi) provides that in the case of a policy of workers' compensation insurance, "covered claim" means the obligation of an insolvent insurer to provide workers' compensation benefits under the workers' compensation law of this state. At issue here is whether the liens of EDD are obligations of CIGA in the context of § (c)(4) of §1063.1. That section reads that "covered claims" does not include any obligation of an insolvent insurer arising out of any reinsurance contracts, nor any obligation incurred after the expiration date of the insurance policy or after the insurance policy has been replaced by the insured or cancelled at the insured's request or after the insurance policy has been cancelled by the associations provided in this chapter or after the insurance policy is cancelled by liquidator, nor any obligation to any state or federal government.

The issue is whether the EDD lien is an obligation to a state as provided for in §1063.1. The EDD is a state agency for purposes of construing Insurance Code § 1063.1(c)(4), the Board concluded.

The Board pointed out that unemployment compensation benefits are funded by employer contributions. UCD benefits are funded by employee contributions. Benefits provided under the Unemployment Insurance Act constitute property rights for purposes

of judicial review. Unemployment Insurance Code §3001 provides that the Unemployment Compensation Disability Fund is continued in existence as a special fund in the state treasury, separate and apart from all other public money or funds of this state. The money and assets of this fund shall be held in trust by the state treasurer and administered under the direction of the director exclusively, for the purposes of this part. Unemployment Insurance Code § 2629.1(e) provides in relevant part that an employer or insurance carrier who subsequently assumes liability is determined to be liable for reimbursement to EDD for UCD benefits which EDD has been paid in lieu of other benefits shall be assessed for the liability by EDD. All funds received by EDD pursuant to this section shall be deposited in the disability fund. When a defendant does not pay indemnity benefits to an injured worker while the workers' compensation claim is being disputed, the worker may apply to the EDD for UCD benefits. By law, and assuming the UCD claim is otherwise valid per EDD requirements, the EDD must pay UCD benefits within 14 days, whether or not the injury is industrially related. In order to obtain reimbursement, EDD is permitted to file a lien in the workers' compensation action. A lien is a claim for payment of a debt secured by the potential proceeds of the applicant's claim. The proceeds of a settlement by C&R are compensation which is subject to lien. Workers' compensation liens are limited to those authorized by statute, L. C. §4903. Under L. C. § 4903(f) the WCAB may allow a lien for UCD benefits by EDD.

EDD pays UCD benefits to an eligible disabled claimant as long as there are funds in the claimant's claim balance. When a claimant exhausts the maximum amount of benefits, no further UCD benefits are payable, even if the claimant continues to be disabled. But if money is reimbursed by defendant based on the allowance of an EDD lien, that amount restored is added to the claim balance, and additional UCD benefits may be paid, up to that balance, if the claimant is disabled or otherwise eligible.

In summary, the Board concluded that the injured worker's claim balance is restored when an EDD lien is reimbursed by defendant for contemporaneous periods of industrial injury per L. C. §4904. Because the worker's claim balance with EDD has been restored, additional benefits may be available for subsequent disabilities.

In the opinion of the Board, Insurance Code § 1063.1(c)(4) does not relieve CIGA of liability for EDD liens because liens are obligations to injured workers, not to the State. Insurance Code §1063.1(c)(4) provides that CIGA's liability for covered claims does not include any obligation to any state. Yet when EDD, a state agency, is reimbursed pursuant to its lien, the reimbursement is for the benefits the Board has found to be the liability of the defendant. In this particular case, the lien represents UCD benefits paid by EDD from the injured worker's claims balance, funded by the worker's contributions and depleted depending upon the adjudication or settlement of the workers' comp claim. The carrier's reimbursement of the lien results in restoration of the claim balance, which then becomes available for additional UCD benefits. Restoration of the claim balance returns the injured worker to the position he or she would have occupied as a UCD claimant had the defendant paid benefits in the first instance. Thus, the reimbursement of an EDD lien is payment of workers' compensation benefits, and CIGA's obligation is to the injured worker rather than EDD. Therefore, Insurance Code § 1063.1(c)(4) does not relieve CIGA of liability for the lien.

The Board rejected the contentions made by CIGA in its prior petition for reconsideration that the EDD lien is not a covered claim because it is an obligation arising from disability insurance excluded by §1063.1 (c)(3)(i), because it is a claim by a government insurer excluded by subsection (c)(5) of the statute and because it is a subrogation claim excluded by (c)(9)(ii) of the statute. Reimbursement of EDD is not a case of one insurance company recouping its losses at the expense of fellow members of the industry. EDD is not a member insured of CIGA. The reimbursement of EDD's lien is payment of workers' compensation to the applicant and to the applicant's account. When the Board allows a lien against CIGA for UCD benefits paid by EDD, the injured worker has a property interest because reimbursement will restore the worker's claim balance should the worker become disabled in the future. On the other hand, if the worker's claim balance with EDD is not restored and the worker suffers a subsequent disability, further UC benefits may not be available because the claim balance will have been exhausted following CIGA's failure to satisfy its liability. In *Karaiskos,* the Board reinstated the order issued by the WCJ and affirmed, except that finding No. 4 was amended to read that Insurance Code § 1063.1(c)(4) does not bar EDD from pursuing its lien against CIGA. The issue of industrial injury and the extent of EDD's recovery, if any, are deferred pending further proceedings and determination by the WCJ, jurisdiction reserved.

In *Viveros* the Board ordered that the lien of EDD was allowed and shall be adjusted by the parties consistent with L. C. § 4904, with jurisdiction reserved, absent adjustment.

7. *Manzano v. Flavurence Corporation* and *Singh v. American Shower Door* (2002) (WCAB Significant Panel Decision) 67 CCC 914.

In two factual situations the Workers' Compensation Appeals Board set aside orders dismissing California Insurance Guarantee Association (CIGA) as a party defendant in claims where date of injury, period of liability under L. C. § 5500.5(a), or other coverage issues, which if decided adversely, would result in CIGA liability. CIGA must remain a party defendant until these threshold issues are determined.

In *Singh*, applicant alleged cumulative injury to his back and all extremities arising from employment by American Shower Door from June, 1998, through February 7, 1999. The injury period was subsequently amended to February 7, 1998, through February 7, 1999. Republic Indemnity Company insured American Shower Door as to workers' compensation liability from March 1, 1997, through March 1, 1998, and California Compensation Insurance was the carrier from March 1, 1998, through March 1, 1999. California Compensation Insurance became insolvant in September, 2000, and CIGA assumed administration of its claims. CIGA sought dismissal, asserting that there was other coverage within the liability period, exculpating it from liability under Insurance Code §1063.1(c)(9). The WCJ issued a Notice of Intention to Dismiss CIGA, followed on December 3, 2001, by an order dismissing CIGA. Republic had filed an objection to the Notice of Intent, but it was not timely routed to the file. Republic then sought reconsideration of the dismissal order. The WCJ recommended that the Petition for Reconsderation be denied because Republic had coverage within the L. C. §5500.5(a) liability period.

In *Manzano*, applicant alleged that he had sustained injury AOE-COE to his neck, head and left shoulder on July 21, 1998, while employed by Parker Personnel, Inc. Parker was insured as to workers' compensation liability by Superior National Insurance. In September, 2000, Superior National was placed in liquidation, and CIGA assumed administration of its claims. In November, 2001, CIGA requested joinder of Flavurence Corporation, alleging it was applicant's special employer at the time of injury, and requested that it be dismissed pursuant to Insurance Code §1063.1(c)(9). On December 3, 2001, the WCJ joined Fremont Compensation Insurance, as insurer for Flavurence Corporation, and dismissed CIGA. Fremont Compensation Insurance sought reconsideration. The WCJ recommended reconsideration be denied.

The Board found that while there are some situations in which CIGA is entitled to dismissal as a party defendant due to other insurance as defined in Insurance Code §1063.1(c)(9), the appropriate time for dismissal is after determination of those issues as to date of injury, liability period, general and special employment or other issues which if resolved adversely to CIGA would result in its liability for benefits. Because there had been no determination of the period of injury in *Singh* and no determination of a general and special employment involving Flavurence Corporation, the dismissal of CIGA in these cases was premature. The case of *Industrial Indemnity Company v. Workers' Compensation Appeals Board (Garcia)* (1997) 62 CCC 1661 was distinguished because in that case there was no dispute as to the L. C. § 5500.5(a) liability period, and there were two solvent carriers with coverage and employment within the liability period.

The orders dismissing CIGA were rescinded, and the matters remanded for further proceedings.

IV Injury AOE-COE

1. *Atascadero Unified School District v. WCAB (Geredes)* (2002) 67 CCC 519.

The applicant, a school bus driver, had an off-duty extramarital affair with a co-worker. The affair became the subject of office gossip. The applicant complained about the gossip to her supervisor, who met with the parties and ordered them to cease the gossip. Though the gossip did cease, the applicant left her employment and filed a claim for psychiatric stress, claiming there was a hostile work environment.

The applicant's psychiatrist diagnosed a major depression due to the stress at work. The defense psychiatrist found injury, but that the problems were due to an abusive marriage and divorce, as well as the extramarital affair. He found that the office gossip only played a small role in the injury. The WCJ found the claim noncompensable, reasoning that the gossip concerned a personal matter unrelated to employment. A Board panel reversed, holding that the gossip was an actual event that occurred in the workplace, and under *Albertson v. WCAB (Bradley)* (1982) 47 CCC 460, the emotional injury, therefore, arose out of and occurred in the course of employment.

The employer filed a petition for a writ of review which was granted. The DCA noted that a finding of industrial causation cannot be made where the workers' duties merely

provided a site for the injury, with the Court citing *Transaction, Inc. v. WCAB (Cornelius)* (1977) 42 CCC 236.

The employment must not be a mere passive element focused on by a non-industrial condition; it must play an active role in the development of the psychological condition. The court said: "An injury that grows out of a personal grievance between the injured employee and a third party does not arise out of the employment if the injury occurred merely by chance during working hours of the place of employment, or if the employer's premises do not place the injured worker in a peculiarly dangerous position. Thus, when a third party intentionally injures the employee and there is some personal motivation or grievance, there has to be some work connection to establish compasability."

The court here distinguished *Albertson's* noting that in that case the emotional injury arose from a conflict between the employee and her supervisor regarding scheduling work hours and a temporary layoff. In this case the gossip was about the applicant's personal life which is not a part of the employment relationship. The nature of the applicant's duties had nothing to do with her injury, it only provided a stage and did not contribute.

2. *City of Oakland v. WCAB (Gullett)* 67 CCC 705.

Comment: Psyche Injury under Labor Code §3208.3(h)

The applicant was a long term employee of the City Parks and Recreation Department. He rose through the ranks and became a middle manager. After Robert Bobb became city manager and Jerry Brown was elected mayor, budgetary pressures arose in late 1998. The parks director informed the applicant that his position would probably be eliminated in the next budget. The applicant's supervisor told him to "think management assistant". He worked in that position for the first half of 1999, being assured that the position was authorized in the budget, but on June 16, 1999 he was demoted without any prior warning as part of a reduction in the work force. He left work and sought psychological counseling. He filed a Workers' Compensation stress claim. The medical reports stated that his stress was due to his demotion. The WCJ held that the demotion, coupled with assurances that his position was safe, substantially caused a psychiatric injury. The WCJ also held that the City failed to carry its burden of proof that their action was done in good faith. The Board panel denied reconsideration.

The DCA granted the City's petition for writ of review. The Court noted that the issue was one of interpretation of Labor Code §3208.3 which establishes the threshold for psychiatric claims by barring claims resulting from lawful, nondiscriminatory, good faith personnel actions. Here the City claims that because its personnel actions were done in good faith, the applicant's claim is barred. The demotion was done with an honest and sincere intent to streamline the City budget, and no evidence suggests deception or unlawful collusion. Budget cuts should be allowed without an employer having to defend psychiatric claims by workers whose jobs were eliminated.

The Court pointed out that no case law defines what is meant by lawful, nondiscriminatory, good faith personnel actions. *In Cotran vs. Rollings Hudig Hall International, Inc.* (1998) 17C4th 93, the court considered what is meant by good faith, but this was in a wrongful termination suit arising out of the firing of a manager for

sexually harassing two employees. In *Cotran* the jury was instructed to assess the objective reasonableness of the employer's factual determination of misconduct. The trier of fact is placed in the position of the reasonable employer in deciding whether the defendant acted responsibly and in conformance with prevailing social norms in deciding to terminate an employee. While the employee should be protected, that protection should not infringe more than necessary on the freedom of the employer to make efficient business decisions.

The Court here says that *Cotran* resembles this case in that both involved personnel decisions possibly favoring one worker over another, leading to an adverse personnel action. Given the legislative history of Labor Code §3208.3, the statute's "good faith personnel action" language has meaning much like the language defined in *Cotran*. The exemption is designed to give the employer some freedom in making regular and routine personnel decisions, such as work evaluation, discipline, transfer, demotion, layoff, or termination. So long as the act is done with objective good faith and the employer's conduct meets the objective reasonableness standard, the statutory exemption applies.

The Court pointed out that the Board relied on the objective good-faith standard laid out in *Cotran* when they decided the case of *Larch (Fleming) vs. Contra Costa County* (1998) 63 CCC 831. In *Larch* the Board said there must be consideration of the totality of the circumstances, not a rigid standard, in determining whether the action was taken in good faith. To be in good faith, the personnel action must be done in a manner that is lacking outrageous conduct, is honest and with a sincere purpose, is without intent to mislead, deceive, or defraud, and is without collusion or unlawful design.

Here the Court says the Board has misapplied the word "objective". The WCJ found a lack of good faith where the conduct was objectively reasonable and nothing outrageous was done, nor any bad intent shown, but merely because the reassurance of job protection was unfounded. The Board has impermissibly introduced "no fault" concept into the analysis converting the "objective" shield into a sword. Under the Board's view, a manager is not acting in good faith, regardless of motives, if hopes are created that do not come to pass.

The Court says this sends the wrong message. It suggests that employers should simply let the axe fall without trying to protect employees by transferring them to a another position.

Even if mistakes were made, they were done in good faith.

The Court does say the City could have done a better job in defending. The supervisor's testimony could have been offered to establish objective good faith. The Court says the applicant's testimony was enough to satisfy the employer's burden. Elimination of the applicant's position was discussed, the applicant was told to think about a management assistant job, he was given one even though by mistake, and he worked in that job for more than five months. The Court concluded the employer acted in good faith. While the precise definition of good faith personnel action may be elusive, its existence is recognizable here. A routine employment activity was done reasonably and without improper intent.

3. *County of Humboldt v. WCAB (Arruda)* (2002) 67 CCC 1093 (unpublished).

Decedent was employed by County of Humboldt in its Welfare Department, where she assisted with determinations of eligibility for MediCal benefits. She worked for the County from October, 1990, until November 6, 1998, when she left her job due to medical reasons. She officially resigned on January 19, 1999.

Decedent suffered from a constellation of physical and emotional ailments, including chronic obesity, kidney disease, hepatitis C, diabetic neuropathy, rheumatoid arthritis, sleep apnea, bipolar disorder, and anxiety disorder. She was a smoker. She suffered from considerable non-industrial stressors arising out of marital and financial difficulties.

Decedent was taken off work on November 6, 1998, by one of her doctors, who diagnosed her with manic depression, viral muri, headaches, and etiology muscle contractions. On November 16, 1998, she suffered a stroke.

Two days before her death on October 20, 1999, a neurologist, Dr. Gambin, saw decedent to evaluate whether her stroke was related to work-related stress. The doctor authored an opinion in which he concluded that decedent's stroke in November 1998 was a "stress related work event." The doctor appeared to assume that applicant was working at the time of her stroke. He refers to problems she was having with a co-employee and supervisor, but does not offer any details. His report does not mention other sources of stress.

Decedent died on October 20, 1999 after an intracerebral aneurysm ruptured as she was beginning to ride a horse on the beach. There was no report of trauma causing or precipitating the rupture.

The death claim was found compensable by the WCJ based upon the finding of Dr. Gambin that the death was caused by work-related stress that aggravated decedent's hypertension, causing the rupture of an intracerebral aneurysm. Dr. O'Brien, reported for defendant. Defendant filed for reconsideration, which was denied by the Board. The Court of Appeal reversed, and annulled the award to decedent's dependent.

The doctors agreed that the aneurysm was a congenital condition not caused by employment. They also agreed that the aneurysm would develop and progress naturally, and that hypertension is a risk factor associated with the rupture of an aneurysm. The medical experts focused on whether there was enough stress at work to aggravate or accelerate the disease process. The doctors agreed that, at times, decedent had high blood pressure readings; they disagreed whether she had hypertension.

The court of appeal summarized the medical evidence at considerable length. It found that the opinion of Dr. Gambin did not constitute substantial medical evidence because it was beyond his expertise; it was based on an inadequate history, and was based upon surmise or speculation. The doctor had not obtained an accurate work history, or history of her non-industrial stressors. The doctor had not sufficiently reviewed the available

medical reports; and had expressed doubt in his own diagnosis of hypertension by suggesting that the question be submitted to her treating cardiologists.

The court held that even if decedent had hypertension, there was a failure in the causation link between it and the rupture of the aneurysm.

The court noted that the case of *Turner v. WCAB* (1974) 39 CCC 780 was the most "liberal" among all the reported cases that considered whether a ruptured blood vessel is a compensable injury. In the *Turner* case it was undisputed that applicant had hypertension and that applicant was working late on the night the aneurysm ruptured. Based upon those facts, the court in *Turner* overturned a finding that the death was not industrial.

The facts here are not the same. It is questionable whether decedent had essential hypertension, and applicant had not worked for defendant for eleven months. The court expressed considerable doubt whether the *Turner* decision should be expanded.

The court held that in light of the record, taken as a whole, that Dr. Gambin's opinion did not constitute substantial medical evidence.

4. *Cuen v. WCAB* (2002) (writ denied) 67 CCC 466.

Applicant, who claimed to have sustained a CT injury to his lower back while employed by defendant as a police officer, also claimed to have injured his back as a compensable consequence of admitted injuries to his neck that were sustained from two separate vehicle collisions.

In an F&O, the WCJ found that the CT claim was barred under Labor Code §3600(a)(10) because it was a post-termination claim and that applicant did not seek treatment until after termination. The WCJ also found that applicant knew at least two years before his termination of the potential connection between the claimed CT and his employment. The WCJ also found that the applicant did not sustain injury AOE/COE to his back as a compensable consequence of his neck injury based upon the lack of any credible medical evidence to support injury to his back.

Applicant filed a Petition for Reconsideration, contending that: (1) applicant's claim for a CT was not barred under Labor Code §3600(a)(10) because applicant did not have sufficient knowledge pursuant to Labor Code §5412 of a CT injury to his low back prior to his termination; (2) the evidence contained in contemporaneous physical therapy records showed lower back injury; and (3) there was substantial medical evidence to support a finding that applicant sustained a low back injury. The WCJ recommended that Petition be denied.

The WCJ stated that this is just the type of claim that §3600(a)(10) was meant to bar, i.e. a claim filed in retaliation for being terminated. Applicant testified that two years earlier he had back pain that he attributed to wearing his heavy equipment belt. The WCJ stated that applicant was without any credibility, and that no reasonable person could find

otherwise. He pointed to applicant's testimony that he had no idea that he was to be terminated, but then notes that applicant had a *Skelley* hearing before termination.

The WCJ also found the applicant's testimony to be incredible because while on suspension he claimed to have excruciating back pain, but did not go to a doctor. After the applicant's termination he attempted to "manufacture" medical documentation for his claim by going to the doctor the very next day.

With respect to the claim that the low back was the compensable consequence of his prior neck injury, the WCJ gave no credence to applicant's medical reports. He noted that the doctor kept changing his opinion.

In denying reconsideration, the WCAB incorporated and adopted the recommendation of the WCJ, and specifically extended great weight to the WCJ's findings on credibility. Applicant filed a Petition for Writ of Review that was denied.

5. *Peovich v. County of Contra Costa,* (2002) (Board Panel Decision) 30 CWCR 128.

Applicant was employed as a custodian by the County of Contra Costa on October 9, 1996. While at work, he experienced a sudden onset of chest and back pain at about 8:30 a.m. He complained to a co-employee and was taken to the hospital where he was found to have a tear in the aorta. The tear was repaired, but he died two days later of a cardiac arrest while still in the intensive care unit. There were no witnesses to decedent's activities immediately before his being stricken, and the self-insured employer denied liability.

An application was filed alleging the death was caused by his employment as a janitor. The matter was set for hearing before a WCJ. At that hearing, the supervisor and fellow employees testified they could not say exactly what the decedent had done that morning. They did know that he began his shift at 6:00 a.m., and he was required to clean the courthouse rest rooms by 8:00 a.m. Cleaning the restrooms necessitated using a mop, a bucket with steel wheels, and a vacuum cleaner. The bucket held up to 32 pounds of water. The hospital records indicated he had been generally performing his custodial duties. Also submitted into evidence was the medical report of Dr. Robert A. Blau, a Qualified Medical Evaluator in internal medicine, who concluded that the work the applicant was doing was physical and of a fairly continuous nature that raised his blood pressure and accelerated the aorta-rupturing process. The doctor concluded those activities were strenuous enough to cause dissection of an already compromised aorta. Also admitted into evidence was the QME report of John B. O'Brien, M.D., who was of the opinion that the aorta dissection was spontaneous in nature. In his opinion, it did not occur in the most likely area for a stress-induced dissection. To qualify as a cause of aortal dissection, strenuous activities such as heavy lifting would be required, according to the doctor.

The judge found that neither the injury nor the death arose out of employment. The judge reasoned that Dr. Blau had an incorrect history, decedent's work on October 9, 1996, was not heavy, and the aorta tear did not occur at the location most commonly susceptible to

tearing as a result of physical activity. The applicant filed a Petition for Reconsideration.

The Board panel, after reviewing the evidence, found that the injury and death arose out of and occurred in the course of employment. The Board first concluded that the error in Dr. Blau's history of the decedent's activities did not affect the validity of his opinion that the light and moderate duty tasks which had to be completed within the first two hours of the employment caused a continuum of increase in his blood pressure which caused the tear in the decedent's already compromised aorta.

The Board next stated that the WCJ's characterization of the decedent's job as relatively light overlooked the use and lifting of a mop bucket weighing 32 pounds, plus the weight of the steel wheels and assembly unit. Lifting and carrying that bucket would be considered heavy lifting along the lines of the type of activity required by Dr. O'Brien to qualify as a cause of the aortal dissection.

The panel next indicated that the facts before it were similar to those in *Clemmens v. WCAB*, 33 CCC 186, which held that when a death occurs under unexplained circumstances on the employer's premises, the employee is entitled to a presumption or inference that the death arose out of employment, since it is undisputed that his employment brought him to the place where his death occurred. Subsequent to the decision in *Clemmens*, however, L. C. § 3202.5 was adopted. This section provides that nothing contained in L. C. § 3202 shall be construed as relieving the party from meeting its burden of evidentiary proof by a preponderance of the evidence. Preponderance of the evidence is defined as that which has more convincing force and the greater possibility of truth. When weighing the evidence, the test is its relative convincing force.

The Board panel explained that Dr. Blau's supplemental report provided credible evidence that death arose out of employment. The effect of the medical evidence turned on whether decedent's activities were sufficiently strenuous to cause the dissection. When viewed in light of the inference that an unexplained death on the employer's premises is compensable and the burden of proof mandated by L. C. § 3202.5, the records support a finding that decedent's work on the morning of October 9, 1996, contributed to the dissected aorta and led to his death.

Accordingly, the panel granted reconsideration, rescinded the WCJ's Finding and Order, and substituted a finding that decedent had sustained a compensable injury that resulted in his death. All other issues except costs were deferred pending further proceedings and decision by the WCJ.

6. *Richard v. W.C.A.B. (Kaiser Permanente Medical Group)* (2002) (writ denied) 67 CCC 195.

Applicant was required to use her car to travel between worksites. While driving between two Kaiser facilities, applicant stopped for lunch, stopped at her bank to purchase money orders for her car insurance payment and make a loan payment. While approaching her car insurance agent's office to drop off the money order, applicant's car

was rear ended. The parties placed the going and coming rule and special mission exceptions in issue. The WCJ found that the extent of the deviations for the various errands run by applicant constituted a deviation from employment, and that she was not in the course of employment at the time of her injury. The Board sustained the WCJ, stating that applicant was in a "substantial detour" at the time of injury. Applicant's Petition for Writ of Review was denied.

7. *Schneider v. Reliance National Insurance Company*, (2002) 30 CWCR 249 (Board Panel Decision).

The deceased had been employed as an assistant physics professor at Stanford University. He had an office on campus, but he was free to come and go from campus as he chose. To avoid being interrupted by students while doing scientific writing, he developed the routine of taking the laptop computer, provided by his employer, to Starbucks and working there.

He was granted a fully-paid sabbatical for the purpose of producing a high volume of world-class research writing for publication. The sabbatical would enable him to conduct research without teaching responsibility. During the sabbatical year, he would have access to his campus office and be required to maintain contact with the students for whom he was advisor. The university expected a significant volume of scholarly research and written output. The university left the method and mechanics of producing the research and writing to the decedent.

The deceased and his wife had been having temporary difficulties scheduling child care for their children. His wife was an M.D. and was working long hours in preparation for maternity leave. No outside care was available between the time summer school ended and summer camp began. Because the decedent did not believe that he could spare the time from his research and writing to care for the children, they decided that he would take the children to their grandparents in New Jersey, who would be responsible for the children six hours a day while the decedent worked.

On arrival in new New Jersey, the deceased located a nearby Starbucks and resumed his routine of working there. While he was doing academic-related work on his laptop computer at the Starbucks, a motorist lost control of his automobile, crashed into the coffee shop, and the professor was fatally injured. An Application for Adjudication of Claim for Death Benefits was filed. By the time the claim was heard, Reliance had become insolvent, and its California claims were being administered by the California Insurance Guarantee Association. The matter came to trial, at which no oral testimony was taken. The case was submitted on exhibits that included a list of all files on deceased's laptop hard drive, which had been open on the day of his death; depositions of applicant; deposition of the chairman of the physics department; deposition of a Ph.D. candidate who had decedent as a faculty advisor; and the department business manager.

After the matter was submitted on the record, the WCJ found that the injury arose out of and occurred in the course of employment. The judge, in her Opinion on Decision, indicated that a change in tortuous legal distinctions needed to be updated due to the use of computers, e-mail, fax machines, cell phone and other devices of convenience to

encompass a new perspective on employment relationships and the manner in which business is conducted in these times. CIGA sought reconsideration, contending the evidence did not justify the finding that the injury arose out of employment and that the injury occurred in the course of employment.

The workers' compensation judge indicated that one of the conditions of compensability is when an injured worker is performing service growing out of and incidental to the employment and is acting within the course and scope of employment. The cases have not limited course of the employment to the employer's premises, but have extended it to reasonable areas of access, travel between work sites, special missions, coffee and lunch breaks, and others. The basic rule to be derived from the cases is that an injury is compensable if it occurred while the employee is doing those things that the contract of employment expressly or impliedly authorized. [*Bramall v. WCAB* (1978) 43 CCC 288.]

Relating these concepts to the facts before her, the WCJ observed that the time and space limits of deceased's employment were defined by the computer provided by his employer. The portable computer encompassed a virtual office, allowing him to communicate with his staff, advisors and colleagues, to work on his research files and to do the writing that he was being paid to produce. Thus, because he was able to work anywhere and at any time, deceased's physical location while on sabbatical was incidental to his employment. His time was limited only by the end of the leave. The employer was aware of, and approved of his, as well as other faculty members, doing research and writing off campus.

Responding to the Petition for Reconsideration, the WCJ wrote that it was undisputed that the professor was working on academic-related matters at the time of the fatal injury. The petitioner offered no evidence that any of the files that were opened and worked on the fatal day were not employment related. The L. C. §3600(a)(2) requirement that the employee be performing services incidental to employment was clearly satisfied.

The WCJ rejected the contention that the professor was not in the course of his employment when struck by the auto. A dual purpose of the trip to New Jersey was to have his parents care for his children to free him to carry on his research and writing. Petitioner's argument that New Jersey was not an authorized work site overlooked the facts that, (1) this was not a going-and-coming rule case, and (2) the uncontradicted testimony established faculty members were free to choose their work environment as long as they produced what was required. The WCJ went on to state that although it was true that Stanford did not expressly direct the professor to be in the Starbucks in New Jersey, he would not have been there if it had not been for the pressures of his employment and the need to produce research papers.

Finally, the WCJ said that the case required her to face squarely the issues of workplace technology and the considerations of modern business. The WCAB owed it to the dependents of the professor to interpret the law in light of the facts presented, notwithstanding petitioner's protestations that the award would open a floodgate of interpretation and create havoc. Each case must be decided on its own facts, and in this case, no evidence emerged that the professor was working on anything other than physics papers for Stanford when killed. A panel denied reconsideration.

8. *Scripps Home Healthcare v. W.C.A.B (Marshall)* (2002) (writ denied) 67 CCC 94.

A WCJ found applicant's injury on a sidewalk in front of Von's where she had stopped to buy a doughnut while en route in her car to work was barred by the going and coming rule. The WCAB on Reconsideration reversed holding that applicant's use of her car was required in her daily work activities, that her commute was therefore within an exception to the going and coming rule, that the stop for a doughnut was a minor deviation not taking her out of the course of employment, and that her injury was therefore compensable. The Court in a per curiam opinion found the Board's determinations supported by substantial evidence, and held that the Board was not required by Labor Code §5908.5 to address each finding of the WCJ in its Opinion after Reconsideration.

9. *Smith v. WCAB* (2002) (Not Published) 67 CCC 715.

In 1988 the applicant was diagnosed with multiple sclerosis (MS). He continued working as police officer for the LAPD. He underwent treatment from time to time, working at a desk job as part of his treatment plan. He occasionally had field assignments such as during the Rodney King riots. At least once he had to stand two hours in the hot sun for a dress inspection. This caused a temporary exacerbation of his symptoms. In March, 1999, he filed a claim for industrial aggravation of his MS. He was evaluated by two QME's, with his QME reporting that his MS was aggravated by certain aspects of work, including exposure to heat. The employer's QME found no relation between the MS and the employment, but both QMEs agreed that exposure to heat can exacerbate MS symptoms. The defense QME said such exacerbation would be temporary, whereas the applicant's QME opined that such aggravation would be permanent.

The WCJ relied on the applicant's QME and found a compensable injury along with 38% permanent disability and need for future medical treatment. The employer filed a Petition for Reconsideration, whereupon the WCJ vacated his decision and conducted further hearings after which he issued the same award. The defendant again sought reconsideration which the Board granted. In a 2 to 1 decision the Board panel felt the applicant's evidence as to the degree of heat exposure was inadequate to support a finding of permanent aggravation of the MS, and they remanded the matter back to the trial judge. The dissenting commissioner felt there was substantial evidence to support the WCJ's opinion. The applicant filed for review which the Court granted.

The DCA set forth the standard of review, indicating that the applicant must establish industrial causation by a preponderance of the evidence, meaning that which has more convincing force and the greater probability of truth. Industrial causation is proven if the evidence showns, with reasonable probability, that the employment proximately caused applicant's MS to "light up", accelerate, or become aggravated.

The Court concluded that the applicant has met the burden of proving that heat exposure aggravated the MS. Both QMEs agreed on that. A review of the medical publications reviewed by the doctors indicated that symptoms may be followed by either complete

recovery or by progression of the disease. Therefore, it is reasonably probable that exposure to heat can permanently change MS. The Court pointed out that there were multiple exposures to heat, especially as reflected in the applicant's QME report. Furthermore, the applicant gave unrebutted testimony that his condition worsened and he had less and less strength in his legs and eventually required a cane. Although his symptoms abated each time after the heat exposure ended, he fatigued more quickly thereafter. The Court said this is convincing evidence that there is a greater probability of truth that the MS was made permanently worse as result of the heat exposure at work. The opinion of the defense QME is inconsistent with the evidence as well as the doctor's own statement that MS can progress with each exacerbation. Since the applicant's evidence satisfied his burden of proof, no further development of the record is necessary. The DCA annulled the Board's decision.

V. Conditions of Compensation

1. *Lewis Tile Company v. WCAB (McCalip)* (2002) (writ denied) 67 CCC 187. The Board panel decision reported last year (below) has been denied review by the Court of Appeal.

Applicant was employed as a tile setter. Applicant and other employees customarily reported to the company shop each morning for their work assignments. Company trucks were used to take employees and tools to job sites, but some employees drove their own cars to the job sites. Although the employer condoned employees taking their own cars to the job site, it did not reimburse employees for use of their personal vehicles.

The employer supplied tools, but the applicant and some others also supplied their own tools. At the end of the day, the employees loaded the company truck for return to the shop where the sand buckets were refilled for the next day. Employees who drove their own cars were not required to return to the shop when they had finished their work assignments.

On November 4, 1998, the applicant and a supervisor were assigned to a remote job site. They finished the job shortly after noon and had no further work to do at that location. The supervisor took the truck, including applicant's tools, back to the shop. Applicant left in own car but did not tell the supervisor where he was going. At the time of the injury, the applicant was headed in the direction of both his home and the shop when he ran off the road and was injured.

Defendant denied liability based on the going-and-coming rule and intoxication defenses. At the hearing on the matter, the applicant testified that he customarily drove his own car because he wanted the freedom to get his own lunch and because he sometimes had side jobs to go to at the end of the day. It was for the side jobs that he used his own tools and carried them in his own car.

Due to his head injury, he had no memory of the events of the day of the injury and had no knowledge why his tools were in the company truck. He inferred from his usual

practice of carrying them in his car that he expected to do additional work for the employer that day. It was unusual for his tools to be in the company truck.

The workers' compensation judge concluded the applicant was "on the clock" at the time of the injury and found that the injury was not caused by intoxication. Defendant petitioned for reconsideration, contending the claim was barred by the going-and-coming rule and by the intoxication defense. In his report and recommendation, the WCJ stated that based on the facts and L.C. §3202, the only reasonable conclusion was the applicant was returning to the shop either to fill the sand buckets and check on last-minute work or to get his tools. The WCAB granted reconsideration for further study.

The Appeals Board panel, after further study, found the judge reached the correct result and denied reconsideration. The WCAB concluded that it was reasonable for the WCJ to infer that applicant was returning to the shop. Based on the scene of the accident, the applicant could have been headed home or back to the shop. Because of the applicant's amnesia, he could not remember where he was going nor what he was doing. Nevertheless, it was reasonable for the judge to infer that the applicant, being the helper, would likely have been responsible for refilling the sand buckets.

The fact the applicant's tools were in the truck supported the judge's conclusion that the applicant was probably returning to the shop. The Board concluded that the judge could reasonably infer that the applicant was returning to the shop either to get his tools, help load the sand, or was checking to see if there were other jobs for the rest of the day.

The panel did not, however, approve of the WCJ's conclusion that applicant was "on the clock" at the time of the injury. The applicant had finished his duties at the site, and there was no evidence either way on whether the employees were being paid for the time spent traveling between the shop and the work sites. The panel also summarily disposed of the intoxication issue by incorporating the WCJ's reasoning that the defendant did not produce sufficient evidence to establish that applicant's injuries were caused by any alleged intoxication. The findings of the WCJ were affirmed.

The DCA denied writ.

2. Lockheed Martin v. W.C.A.B. (McCullough) (2002) 67 CCC 245.

Applicant sustained an admitted industrial injury to her left forearm and was awarded a 35½ % permanent disability. The applicant filed another claim alleging a CT pulmonary and internal injury, later adding an allegation of psychiatric injury. The applicant sustained an admitted cumulative trauma injury to her right upper extremity, neck, and alleged psychiatric and internal injuries.

The WCJ found the applicant did not sustain injury to her pulmonary, internal organs or psyche arising out of and occurring in the course of employment, but did sustain injury to her right arm and neck and was awarded a 27 ¾ % permanent disability.

The WCJ found that applicant's psychological state did not satisfy the threshold of compensability established by L. C. §3208.3, subdivision (b)(1), which the judge ruled was applicable to all psychiatric injuries, even those incurred as a consequence of physical work injury.

The applicant filed a petition for reconsideration in which she asserted L. C. §3208.3 does not apply to psychiatric injury that is a compensable consequence of an orthopedic injury. The Board granted reconsideration and reversed the WCJ, finding that under the case of *Rebelo v. Washington Hospital* (1999) 27 CWCR 159, that the applicant did sustain a psychiatric injury as a compensable consequence of the admitted industrial physical injury. Based on Rebelo, the Board ruled that L. C. §3208.3 did not apply to a compensable consequence of a physical injury.

In 1991 L. C. §3208.3 was amended. In subdivision (b) it stated, "Nothing in this section shall be construed to mean there shall not be compensability for any psychiatric injury which is related to any physical injury in the workplace." L. C. §3208.3 was again amended in 1993, and the above-quoted language was deleted from the section.

In the case of Rebelo, the Appeals Board ruled that L. C. §3208.3 did not apply to a psychiatric injury that is alleged to be a compensable consequence of a physical injury. Despite the omission of the language in the 1993 amendment, the Board nevertheless found it worthy of note that the legislature did not disturb the long-standing rule of compensable consequence when it enacted L. C. §3208.3.

Although the compensable consequence doctrine has a long-standing foundation in workers' comp law, the Board panel continued, compensable consequence injuries are nowhere described in L. C. §3208.3. There was no appellate review of the Rebelo case, and the Board expressly followed its rationale in two other writ-denied cases. In this case, the workers' compensation judge found that he was not bound by panel and writ-denied decisions, and found that L. C. §3208.3 does apply to a compensable consequence of a physical injury.

The Court of Appeal indicated in their decision that there had been no appellate authority on this issue. They further indicated they were not bound by either Board panel decisions, such as Rebelo, or writ-denied cases. The Court indicated the language of subdivision (b)(1) clearly and unambiguously refers to compensability of "psychiatric injuries" without any exceptions. The legislature undoubtedly knows how to enact an exception, as it did in 1991, and the fact that it later deleted that exception would appear determinative.

The court concluded that, at least since 1993, a compensable consequence injury is governed by L. C. §3208.3, and the precipitating physical injury constitutes an actual event of employment within the meaning of subdivision (b)(1); that is, a consequential psychiatric injury is compensable if, and only if, it is more than half attributable to the physical industrial injury.

The WCJ correctly ruled that L. C. §3208.3 applies to all claims of psychiatric injury, including those resulting from physical work injuries, and the Board erred in reversing that ruling.

3. *Northrop Grumman Corporation v. WCAB (Graves)* (2002) 67 CCC1415 (certified for partial publication).

Annette Schroeder accused the applicant of treating Mr. Lowe, an African-American man, more harshly than other employees. Ms. Schroeder, a Northrop employee, made the racial discrimination allegation in a March 22nd, 1998, written statement. Ms. Schroeder also said Mr. Graves spoke to Mr. Lowe in a demeaning manner. Ms. Schroeder further said she had commented to Mr. Lowe that he didn't have to take that from anyone, but Mr. Lowe said yes, he did, because he needed Mr. Graves to approve his work, and he didn't want any trouble from him.

Two supervisors were notified of the written allegations and spoke to Mr. Lowe. Mr. Lowe confirmed that he felt he was being treated more severely than his coworker and believed it was racially motivated. The two supervisors then contacted employee relations for assistance. Employee relations then interviewed Mr. Lowe. Mr. Lowe stated in the interview he felt Mr. Graves had been treating him differently than other trainees and that he believed it must be because of his race, as he could determine no other reason. Mr. Lowe raised the following concerns: Mr. Graves was giving favors to some trainees while making Mr. Lowe take measurements more accurately than others; in contrast to other trainees, Mr. Lowe was given no room for error; Mr. Graves would approve measurements made by other trainees without checking the work; Mr. Graves delayed responding to Mr. Lowe's request to approve measurements; this resulted in Mr. Lowe having fewer approved measurements, and the delay increased the probability that Mr. Lowe's equipment would be jarred, affecting the accuracy of his measurements. When the trainees achieved a particular level of accuracy in their measurements, they would receive a special job classification and a 50-cent-per-hour salary bonus. Employee Relations advised Applicant's supervisor of the allegations. The supervisor and Employee Relations agreed to undertake a joint management Employee Relations investigation. The supervisor obtained and compared all trainees' certification sheets. Analysis of the certification and computer data showed: Mr. Graves approved measurements by two employees, and one employee's measurements had been copied from the other employee's data; Mr. Lowe was the only trainee with a particular negative notation; and the applicant had disapproved an inordinate number of his measurements.

Interviews were also conducted with other trainees. These interviews revealed that the applicant allowed trainees to check each other's work. When the trainees checked each other's measurements, the applicant would give his approval without verifying the accuracy of the work. One of the trainees indicated that he believed the applicant was particularly hard on Mr. Lowe. One trainee confirmed that he had checked other trainees' work. It was confirmed that the applicant then approved the trainees' work without personally checking its correctness. An investigative report also indicated that the applicant was unavailable during a long period of time on the weekends, and they

believed that the applicant would go to his car in the parking lot and sleep for an hour or two.

The Employee Relations representative then met with the applicant. He admitted certifying as accurate the certification that was recreated by one employee copying from another; he further indicated that one trainee was permitted to inspect the work of other trainees, and he approved those measurements without personally inspecting the work. He denied sleeping in his car on the weekends, although he could not account for the time off site on one date. He denied treating Mr. Lowe differently than other trainees.

Following the investigation, it was determined that the applicant would be disciplined. He was issued a final warning notice and given a three-day disciplinary suspension for gross negligence in the performance of his duties as well as for causing discord within the workplace by treating employees in a different manner with different requirements. The applicant was found to have used his quality assurance stamp in a manner inconsistent with stamp policy and procedures by stamping work that he did not inspect in assisting in the re-creation of a document that was inaccurate and would be to the employee's benefit. It was further determined and agreed that it could not be determined that Mr. Lowe's disparate treatment was the result of race, but that the disparate treatment was apparent and that the company should take appropriate action which would be the same, regardless of whether it was due to race or some other basis.

The applicant testified he did not have any problems on the job until he was accused of racial discrimination. He had been evaluated on an annual basis, and always rated outstanding. The WCJ's evidence summary states that before March the applicant received some less than outstanding marks, but he was never marked down until after the complaint was filed by his supervisor. The applicant's supervisor did not talk to the applicant after the complaint.

The investigator for Employee Relations indicated that the disciplinary action was based only on the falsification of documents and the finding that the applicant had treated Mr. Lowe in a disparate manner. They were unable to state whether the disparate treatment was based on race or ethnicity. The racial discrimination charge was never substantiated. The applicant received a three-day suspension, however, because his offenses were major as defined in the employee's handbook. The applicant then filed a grievance. The suspension was subsequently reversed.

Dr. John Beck, a psychiatrist, found the applicant to be suffering from a major depressive disorder in partial remission. Dr. Beck found there was a direct relationship between the work exposure and disability, stating: Absent the harassment and the age discrimination from which the applicant suffered, there would have been no psychiatric work function impairment; and age discrimination is a clear violation of labor laws, as is allowance of a hostile work environment where harassment may be practiced. Dr. Beck concluded actual events of employment were responsible for one hundred percent of the total causation from all sources contributing to the current psychiatric disability.

Dr. Stanley Goodman, a psychiatrist, concluded that the applicant was falsely charged as a racist and was eventually absolved of those insinuations. The patient has significant

psychosocial stressors, that is the cumulative traumatic incidents, which he received perceived at work. Dr. Goodman also found, the industrial stressors of job harassment and age discrimination did produce an industrially related psychiatric injury. Dr. Goodman concluded that one hundred percent of the disability was apportioned to industrial causes. The doctor noted the applicant continued to be harassed and suffered age discrimination until he was eventually asked to retire. There was a hostile work environment created by his manager and the Employee Relations representative who interrogated him.

Dr. David Appleton, a psychologist, evaluated Applicant on behalf of Northrop. He concluded that the applicant developed a depressive disorder as a result of a personnel action at work, specifically his suspension and written reprimand for the misuse of his inspector stamp. There were also allegations the applicant was involved in racial discrimination. As long as the personnel action in question was carried out in a lawful good faith and nondiscriminatory manner (and while the patient alleges age discrimination with respect to this, he admits he misused his stamp), then the depressive disorder would not represent a compensable psychological injury under current workers' compensation law.

The WCJ, following the hearing, found the applicant had sustained a psychiatric injury arising out of and occurring in the course of his employment. The WCJ relied on the applicant's testimony and the medical reports of Drs. Goodman and Beck. The WCJ concluded that Applicant's injury resulted from a false accusation of racial prejudice by the employer and harassment by his supervisor after the charge of racial prejudice could not be proven. The judge concluded no lawful good faith personnel action constituted a substantial cause of the injury. Defendants filed a Petition for Reconsideration. The WCJ recommended that reconsideration be denied. In his report, he noted the applicant was a very credible witness and that the applicant had no problems on the job until he was accused of racial discrimination against an employee and that the charge was never substantiated. The WCJ concluded that the allegation of racial discrimination against the applicant was not made in good faith, it was never proven since there was a lack of evidence to support it. The applicant was never disciplined as a result of the racial discrimination charge. The only disciplinary action taken was for falsification of company documents. Following the charge, Mr. Johnson, an African-American, would not talk to Mr. Graves anymore and then downgraded his performance evaluation. The WCJ concluded that the applicant's psychiatric injury was caused by the baseless charge of racial discrimination and the investigation that followed. It was not the result of a good faith personnel action; it was the result of a completely unsubstantiated charge of racial discrimination. The WCJ went on to state that the applicant was 66 years old at the time, and there is evidence that he was being forced to retire possibly because of his age, and the investigation was not in good faith, and it singled out the applicant in order to have him leave the company. The Board, on reconsideration, adopted the WCJ's report and recommendation and denied reconsideration.

The Court of Appeal indicated the right to compensation for work-related psychiatric injuries is described in L. C. §3208.3 subdivision (a), as follows: Psychiatric injury shall be compensable if it is a mental disorder which causes disability or need for medical treatment, and it is diagnosed pursuant to procedures promulgated under paragraph (4)

of subdivision (j) of L. C. §139.2 or until these procedures are promulgated, it is diagnosed using the terminology and criteria of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised, or the terminology and diagnostic criteria of other psychiatric diagnostic manuals generally approved and accepted nationally by practitioners in the field of psychiatric medicine. The relevant exception in this case to the compensation right in the case of a psychiatric injury is set forth in L. C. § 3208.3, subdivision (h), which states: No compensation under this division shall be paid by any employer for a psychiatric injury if the injury was substantially caused by a lawful nondiscriminatory good faith personnel action. The burden of proof shall rest on the party asserting the issue. The term "substantially caused" in L. C. §3208.3, subdivision (h), is defined in L. C. §3208.3, subdivision (a)(3) as follows, "For the purposes of this section, 'substantial cause' means at least 35 to 40 percent of the causation from all sources combined."

The Court of Appeal went on to state that L. C. §3208.3 does not define lawful nondiscriminatory, good faith personnel action. However, the Court of Appeal in the *City of Oakland v. WCAB* (2002) 67 CCC 705 stated that the words at issue have a meaning similar to the language construed in *Cotran v. Rollins Hudig Hall Internat Inc*. (1998) 17 Cal 4th 93. In *Cotran*, the employer fired a manager after conducting an investigation into allegations he sexually harassed two employees. When the manager sued for unlawful termination -- violating an implied promise not to terminate without good cause, the trial court instructed the jury that the employer was required to prove the sexual harassment took place. *Cotran* concluded that the question was not whether the sexual harassment in fact took place, but whether at the time of the decision to terminate his employment was made, defendants acted in good faith and while following an investigation that was appropriate under the circumstances, had reasonable grounds for believing plaintiff had done so. *Cotran* explained that the jury's role was to assess the objective reasonableness of the employer's actual determination of misconduct. The Court described this as an objective good faith standard and explained that coupling good faith and objectivity is intended to place the trier of fact in a position of the reasonable employer in deciding whether the defendant in a wrongful termination suit acted responsibly and in conformity with prevailing social norms in deciding to terminate an employee for misconduct. The proper inquiry for the jury is: "Was the factual basis on which the employer concluded that a dischargeable act had been committed reached honestly after an appropriate investigation for reasons that are not arbitrary or pretextual?" In *City of Oakland*, the Court of Appeal concluded the legislature's good faith personnel exemption is meant to furnish an employer a degree of freedom in making its regular and routine personnel decisions such as discipline, work evaluation, transfer, demotion, layoff, or termination. If a regular routine personnel decision is made and carried out, the subjective good faith and the employer's conduct meets the objective reasonableness standard, then the L. C. §3208.3 exemption applies. The Court of Appeal further agreed with the Board's interpretation of the good faith standard in *Larch v. Contra Costa County* (1998) 63 CCC 831. The Court of Appeals stated they agree with the Board's importation of the objective good faith standard from *Cotran* and *Larch* quoted extensively from *Cotran,* borrowing the objective good faith standard in explaining in its own words, that any analysis of the good faith issue must look at the totality of circumstances, not a rigid standard, in determining whether the action was taken in good faith. To be in good faith, the personnel action must be done

in a manner that is lacking outrageous conduct, is honest and with a sincere purpose, is without an intent to mislead, deceive, or defraud, and is without conclusion or unlawful design. We agree with the well-stated legal analysis in *City of Oakland*. In this case, the WCJ found that what occurred was not a lawful, nondiscriminatory, good faith personnel action within the meaning of L. C. §3208.3, subdivision (h). In the opinion of the Court of Appeal, this finding is not supported by substantial evidence. The Court indicated that to begin with, this investigation was mandated by law. Racial discrimination in employment is prohibited by both state and federal law. The right to hold employment free of discrimination on the basis of race, among other protected classifications, is a civil right. The prohibition against workplace racial discrimination is a fundamental public policy. Public policy of the State of California is to protect and safeguard the civil rights of all individuals to seek, have access to, obtain and hold employment without discrimination because of race. Moreover, employers must take all reasonable steps necessary to prevent discrimination and harassment from occurring. The employer's duty to prevent harassment and discrimination is affirmative and mandatory. Prompt investigation of a discrimination claim is a necessary step by which an employer meets his obligation to ensure a discrimination-free work environment.

In the present case, the applicant's psychiatric injury was caused by an accusation and investigation of what the WCJ concluded was a baseless, unsubstantiated charge of racial discrimination. In his Opinion on Decision, the WCJ found that the applicant suffered this injury from a false accusation of racial prejudice by the employer, and harassment by his supervisor, after the charge of racial prejudice could not be proven. None of the actual events were lawful, good faith personnel action constituting a substantial cause of injury. The WCJ's recommendation on reconsideration noted the allegation of racial discrimination against the applicant was not made in good faith, it was not proven since there was a lack of evidence to support it, and the applicant's emotional complaints began after the baseless charge of racial discrimination was weighed against him. The WCJ indicated that the applicant's psychiatric injury was the result of a completely unsubstantiated charge of racial discrimination and the applicant's psychiatric injury was the result of an investigation on the charge of racial discrimination not made in good faith.

The Court of Appeal then indicated the employer faced with the accusation made by a co-worker that a supervisor engaged in racial discrimination against a subordinate has a legal obligation to investigate the claim. Here the accusation was made by a co-worker of the alleged target. On questioning, Mr. Lowe stated he believed he was being discriminated against because of race. Mr. Lowe cited plausible examples of racially discriminatory conduct by the applicant. That Northrop was later, after investigating the racial discrimination claim, unable to substantiate the accusation did not remove the investigation from the realm of good faith personnel actions. Northrop had a legal obligation to investigate the charge made by a co-worker and corroborated by an alleged victim. Northrop did not have the option of doing nothing. The investigation revealed the applicant had in fact treated an African-American trainee disparately. Northrop's investigation found no evidence the disparate treatment was racially motivated. There was no evidence of an arbitrary or unlawful motive in Northrop's investigation. There was no evidence of intent to mislead, deceive, defraud, or of collusion or unlawful design by a Northrop employee. In fact, the investigation disclosed the applicant in

training employees for work in a classified project, allowed trainees to evaluate each other's work in violation of Northrop's policies. Further, a trainee had simply copied other's work and been allowed to do so by the applicant. Suffice to note, investigating such misconduct by a supervisor employed by a defense contractor is altogether fitting and proper.

The award in this case rests on the WCJ's factually unsupported conclusion that Northrop's personnel action was not undertaken in good faith. The extent to which the WCJ believes Applicant's psychiatric injury arose from subsequent reported harassment at the hands of his supervisor is unclear. The WCJ made only passing reference to harassment by the supervisor.

As stated above, the applicant's psychiatric injury was not compensable if it was substantially caused, at least 35 to 40 percent of causation, from all sources combined. On the record the Court stated we cannot say whether Northrop's lawful nondiscriminatory personnel action was at least 35 percent the causation. Accordingly, this matter was remanded to the Board for further consideration consistent with the decision.

The above portion of the opinion is certified for publication. The only part of the decision not certified for publication is part (3)(c) dealing with L. C. §5908.5. The unpublished part of the decision dealt with Defendant's claim that the Board's Order Denying Reconsideration failed to comply with L. C. §5908.5 which states that any decision of the Appeals Board denying a Petition for Reconsideration shall state the evidence relied upon and specifically specify in detail the reasons for the decision. The Board may, as it did here, incorporate WCJ's report so long as the report details the facts and reasons for the decision

The workers' compensation award in favor of the applicant was reversed, the matter was remanded.

4. *Verizon/GTE v. WCAB (Garth)*, (2002) (writ denied) 67 CCC 856.

Applicant filed a CT claim alleging injury to her psyche, gastrointestinal system, and high blood pressure due to harassment during her employment. Defendant contended that the claim was barred by L. C. § 3208.3 due to good faith personnel action and that applicant's high blood pressure was non-industrial. Applicant's claim of injury resulted from situations at work, including problems with her supervisors, completing payroll when the number of employees increased, and a three-day suspension from work for which applicant sought medical treatment. The evidence at trial indicated the applicant was distraught over the events at work, warranted or not. Prior to the problems at work, applicant did have slightly high blood pressure, but did not use medication. Since her work suspension, applicant has been taking hypertension medication. Her blood pressure did not return to its pre-injury level.
The WCJ issued a decision in which he found the applicant sustained an industrial aggravation to her high blood pressure, but no industrially related gastrointestinal injury and no psychiatric injury pursuant to L.C. § 3208.3.

Defendant filed a petition for reconsideration contending the WCJ erred in finding that applicant sustained injury in the form of high blood pressure while at the same time finding the psychiatric injury was barred by L.C. §3208.3.

The WCJ recommended that reconsideration be denied. In his report the WCJ stated that applicant's exposure to the pressures at work allegedly caused injury to her psychiatric state, not found to be industrial due to the new and higher threshold, and due to her internal system. The judge further wrote that it is understandable that defendant believes both parts are intertwined. However, both body parts claimed to be injured are affected in different ways. One is purely mental, which must have a diagnosis on the DSM-IV and affect the applicant in eight work-function impairment categories, while the other can be objectively measured. It was the manner in which the psyche is affected and the measure which the legislature undertook to create a higher threshold, not internal body parts. Any such change should be brought about legislativly.

The WCAB adopted and incorporated the WCJ's decision and denied consideration without further comment. The writ of review was denied.

VI Presumptions (except presumption of correctness of primary treating physician).

1. *Garcia v. Zurich American Insurance*, (2002) 30 CWCR 254 (Board Panel Decision).

Applicant filed an application alleging that she sustained injury to her right kidney in the course of employment as a ski instructor. Defendant, Zurich Insurance Company, the employer's insurer, denied liability, and a Mandatory Settlement Conference was scheduled. At the MSC, the parties submitted a statement of the issues in dispute, listed the exhibits and disclosed witnesses. Included in the designated evidence were the denial letter and defendant's investigative notes. No mention was made of the L. C. §5402 presumption that if liability is not rejected within 90 days, the injury is presumed compensable.

At trial a month later, applicant sought the benefit of the presumption. Defendant objected that the issue had not been raised at the MSC. The WCJ ruled that the presumption had been waived by applicant's failure to assert it before trial. A Petition for Removal was filed. The panel had indicated that in the en banc decision of *Davis v. Wausau Insurance,* (2000) 65 CCC 1039, it had said that the L. C. §4062.9 presumption could be raised at trial when the facts making it operative had been entered into evidence, but it could not be asserted for the first time on reconsideration.

A presumption becomes operative when the facts giving rise to it have been established by stipulation, evidence or judicial notice.

In *Gee v. WCAB*, (2002) 67 CCC 236, the Court of Appeal rejected the Board's holding in *Davis* that the presumption had to be raised as a separate issue. The panel explained that the issue in *Gee* was whether the L. C. §4062.9 presumption was applicable, even though

applicant had not asserted it until her Petition for Reconsideration. The Court held that because the presumption was statutory, the WCAB had to take judicial notice of it. Consideration of the L. C. §4062.9 presumption was mandatory and not dependent on whether the party raised it as an issue. Whenever the presumption's underlying conditions are established, the trier of fact has to adopt the initial assumption that the treating physician's findings are correct.

The *Gee* Court also considered and rejected the prejudice-to-the-defendant argument. The Court stated they found no significant prejudice to an opponent, or inconvenience to the WCAB, in not raising the treating physician's presumption as a specific issue during the workers' compensation proceedings. Under L. C. §4062.9, the parties and the trier of fact all have adequate notice of the presumption's applicability whenever the underlying facts are established. However, consistent with the WCAB's goal of facilitating judicial economy, parties should raise any objection to the presumption's underlying factual conditions early in the litigation and no later than trial.

The panel went on to state that, although *Gee* did not involve the L. C. §5402 presumption, the panel deems that holding to be controlling. A statutory presumption affecting the burden of proof becomes operative when the basic facts giving rise to it are established, not when a party raises the issue. As in the case with the L. C. §4062.9 presumption, application of the L. C. §5402 presumption is mandatory when the factual basis for it is established. It was not clear from the record before the Board, however, whether the operative facts had been established. The panel explained that the documentary evidence shows the employer knew applicant had been injured, but there was a question as to whether it knew applicant was claiming the injury occurred while she was on the clock. The WCJ would have to determine whether the employer had sufficient knowledge to be reasonably certain that an injury had been suffered or that applicant was claiming an industrial injury.

Applying the reasonable certainty standard, the Board's decision in *Wagner v. Zurich American*, (2001) 29 CWCR 103, 66 CCC 483 (en banc), the WCJ must determine if the employer had sufficient knowledge of an injury or claim to trigger it's duty to provide a claim form as required by L. C. §5401(a). That standard requires a finding that the employer was reasonably certain that applicant suffered or claimed to have suffered an industrial injury. An employer is not required to guess or speculate as to an employee's unannounced intentions or nebulous, ambiguous comments that only remotely imply the possibility of injury or claim of injury. The standard is, however, meant to impose the duty to investigate on an employer that is aware of facts that would lead a reasonable person to conclude with some certainty that an industrial injury occurred or is being asserted.

Accordingly, the panel ordered the case removed to itself and amended the WCJ's finding, to provide that the L. C. §5402 presumption may be raised for the first time at trial, and returned the case to the WCAB with instructions to determine whether, (1) the employer had adequate knowledge of applicant's claim to trigger its duty to investigate, and (2) if so, when the duty arose and whether the denial of the claim was timely.

2. Honeywell, formerly known as Allied Signal Aerospace Company v. WCAB (Wagner) December 20, 2002, Court of Appeal, 2nd Appellate District 67 CCC____.

Applicant claimed work-related headaches and injuries to his psyche and skin due to his employment. Honeywell provided an on-sight medical clinic which recorded medical information reported by employees. Wagner's medical record dated July 20, 1998, indicates he informed the clinic that management was prejudiced against him and hampered his promotion and transfer. The record also reflects that Wagner stated 1) he could not take it anymore, 2) his wife wanted him to quit due to stress, 3) he had lost 30 pounds, 4) he was anxious and agitated, and 5) his doctor prescribed medications for work stress. On October 16, 1998, applicant was admitted into a psychiatric hospital, and his wife called Honeywell and left a message with the human resources disability coordinator to the effect that her husband had been hospitalized and that his supervisor and others at work continued their head games and pushed her husband over the edge. On January 10, 1999, applicant faxed to Honeywell a medical leave request form which was checked that injury was work-related. In a letter to applicant dated January 11, 1999, Linda Wood, who was in personnel and handled workers' compensation, wrote that she had received the information from the medical department and was enclosing a claim form and a pamphlet explaining workers' compensation. On about January 13, 1999, applicant retained an attorney and completed a claim form which was served on Honeywell on January 15, 1999. Honeywell then denied the claim by letter dated March 31, 1999.

In support of his injury claim, applicant obtained a medical report from his treating psychiatrist, Thomas Curtis, M.D. Dr. Curtis diagnosed major depression with anxiety and panic attacks which were industrial. Honeywell obtained a rebuttal medical opinion from a psychologist, Dr. Framer, who concluded applicant's psychiatric condition was caused by a good faith personnel action, and thus was not compensable, or non-industrial factors.

At trial, the matter was submitted to the WCJ, without testimony, in order to determine whether the injury should be presumed compensable under L. C. §5402. The WCJ found that the 90-day period under L. C. §5402 had ended on January 15, 1999, and the psychiatric injury was presumed compensable unless rebutted by evidence not available by that date. The WCJ explained that Honeywell had sufficient information and notice as of July 20, 1998, to require the provision of a claim form. Even if that were not so, the WCJ wrote that the very latest the claim form should have been provided by Honeywell was following the contact with applicant's wife on October 16, 1998. The WCJ stated that his decision was supported by principles of estoppel, citing *Shoai-Ahari v. Zenith* (1992) 21 CWCR 14, or that the duty arose upon demand, citing *Janke v. State of California* (1991) 19 CWCR 310. In *Janke*, the employer and insurer refused to provide a claim form when requested by an employee who was claiming a psyche injury. The WCAB panel held that the 90-day period allowed to the employer under L. C. §5402 had expired because it had commenced to run when the employer received knowledge of the injury claim and had deliberately refused to provide the claim form to the employee. The WCAB panel, in Janke, found such conduct to be egregious and stated it would not allow the claim procedures to be manipulated intentionally or negligently so as to extend the period in which a claim form must be accepted or rejected. In this case, Honeywell filed

a petition for reconsideration. In his report and recommendation on reconsideration, the WCJ recommended that the WCAB affirm the decision, because Honeywell was twice placed on notice of the industrial injury claim, thus creating a duty to investigate and provide the claim form.

The WCAB granted reconsideration and issued an En Banc decision in *Wagner v. Allied Signal Aerospace* (2001) 66 CCC 483. It held that the 90-day period alternatively begins when an employer is reasonably certain of an industrial injury or claim and breaches the duty to provide the claim form, citing *Janke* and *Thompson v. County of Stanislaus* (1996) 25 CWCR 24. The WCAB further held that when the employer belatedly provides the claim form, the 90-day period is tolled until the completed claim form is filed by the employee. The WCAB indicated it was persuaded by comments in *Janke* that L. C. §§5401 and 5402 were intended to encourage employers to promptly provide benefits or investigate claims, which should not be circumvented by the failure to provide a claim form. The WCAB rescinded the WCJ's decision and remanded the matter for application of the reasonably certain standard. The reasonably certain standard was basically defined as awareness of facts that would lead a reasonable person to conclude, with some certainty, rather than by guess or speculation that an industrial injury, as set forth in the L. C. §5401, subdivision (a), had occurred, or was being asserted. The WCAB also remanded for the record to be further developed, if needed, to determine whether the employees involved had sufficient authority to impute notice or knowledge to Honeywell.

The parties again proceeded to trial before the WCJ. The applicant's wife testified regarding the message she left at Honeywell and her conversations with Nyssa Hawkins. She testified that she was reasonably certain that applicant's wife was reporting a work injury, which Hawkins communicated to Linda Wood, from personnel, within a few days. Wood denied that Hawkins reported an injury concerning Wagner, nor did Wood recall being informed about a phone call from Linda Wagner. Wood further testified that she would not provide a claim form if the injury was reported by a third party, unless informed it was work-related. Wood also stated she knew that the applicant had been hospitalized in October 1998, and although she had heard from the medical department that he was out on stress, possibly due to events at work, he did not report an injury to her.

The WCJ found the 90-day period under L. C. §5402 had expired on January 15, 1999. The WCJ explained that Hawkins, who was reasonably certain an industrial injury had occurred, had reported it to Wood and a claim form should have been provided no later than October 16, 1998. Therefore, the psychiatric injury was presumed compensable. Honeywell filed a Petition for Reconsideration. Honeywell alleged that the reasonably certain standard was contrary to the plain language of L. C. §§5401 and 5402, which also required the claim form to actually be filed with the employer in order for the 90-day period to begin. Even if the reasonably certain standard is valid, argued Honeywell, it was incorrectly applied because Hawkins was not the proper person to receive notice of the injury or claim, and Wood testified she was not informed. Honeywell also asserted that its conduct did not justify estoppel under *Janke*.

In his report on reconsideration, the WCJ added that Wood admitted she knew that Wagner was out on stress, possibly due to events at work. He also reasoned that Hawkins was the disability coordinator and it was not the employee's burden to ferret out the precise person, among many, to whom a claim should be made.

The WCAB adopted the WCJ's findings and denied reconsideration. The WCAB concluded that the legislative policy of encouraging prompt investigation and processing of claims was facilitated by applying the presumption of compensability when the employer is reasonably certain that an injury has occurred and fails to timely provide a claim form. Honeywell filed a Petition for Writ or Review.

Wagner claims that the arguments being made were finally decided in the *en banc* decision and therefore the issues were not timely appealed by Honeywell.

On review, the Court indicated at the outset that the Petition for Review was timely. The Wagner *en banc* decision was not an appealable decision. The WCAB simply rescinded the WCJ's original decision and remanded the matter to determine whether the presumption of L. C. §5402 applied under the reasonably certain standard and for further development of the record.

The Court then, discussing the standard of review, indicated that interpretation of the governing statute is decided *de novo* by the Appellate Court, even though the WCAB's construction is entitled a great weight, unless clearly erroneous. When interpreting a statute, the legislature's intent should be determined and given effect. The best indicator of legislative intent is the plain meaning of the statutory language, when clear and unambiguous. Effect also should be given due to the statute's every word and clause, thereby leaving no part or provision useless, deprived of meaning or contradictory. Finally, the statute should be interpreted consistently with its intended purpose, and harmonized within the statutory framework as a whole.

The Court of Appeal then indicated, in essence, that it appears the WCAB has simply created the term "reasonably certain" and substituted it for the statutory language, notice or knowledge of injury under L. C. §§5400 or 5402 set forth in L. C. §5401, subdivision (a). The Court found that the plain language of L. C. §5401, however, is a clear and unambiguous expression of legislative intent. The notice or knowledge that requires a claim form by the employer under L. C. §5401, subdivision (a), is the written notice of injury in L. C. §5400, or the knowledge of an injury or assertion of a claim of injury sufficient to afford the employer an opportunity to make an investigation into the facts in L. C. §5402. This inter-related and detailed language indicates the legislature intended a precise definition as an integral part of this statutory scheme. Knowledge of an injury or claim of injury coupled with opportunity to investigate are the essential components of the statutory scheme. Such purpose is frustrated, if not totally undermined, by the introduction of the ambiguous concept "reasonably certain." Indeed, as we understand the WCAB's use and application of the term "reasonably certain," it adds nothing to the knowledge or notice of the employee's injury claim which, under the express language of L. C. §5401, subdivision (a), triggers only a duty to provide a claim form, not the commencement of the 90-day investigatory period provided for in L. C. §5402. While the WCAB is empowered to enact rules and regulations, it may not create and change

legislation that was within the plenary power of the legislature under Article XIV, section 4, of the California Constitution. The WCAB also may not exceed its authority by creating exceptions to statutory requirements, even for a legitimate purpose.

The statutory language regarding the commencement of the 90-day period in L. C. §5402 is very straightforward. That section clearly provides that liability must be rejected within 90 days after the completed claim form is filed under L. C. §5401. Under subdivision (b) of L. C. §5401, the claim form is deemed filed when it is personally delivered to the employer or received by the employer by first class or certified mail. The only reasonable reading of this clear statutory language is that the 90-day period commences to run from the date the claim form is actually filed with the employer.

Nevertheless, the WCAB concluded the 90-day period also will commence to run whenever an employer breaches the statutory duty to provide a claim form. This judicial remedy is too broad considering precedent, the plain language of L. C. §§5401 and 5402, and the legislature's expressed intent to provide a 90-day investigatory period which begins with the filing of a claim with the employer. The WCAB has effectively rewritten L. C. §5402 to eliminate the provision that the 90-day investigatory period commences upon the filing of a claim form.

We recognize there are certain circumstances in which a judicial remedy, such as estoppel, are proper in order to accomplish statutory goals. However, a judicial rule that also lessens or eliminates the employer's statutory opportunity to investigate the employee's injury, which results in the injury being presumed compensable while excluding contrary evidence, should be sanctioned only in very limited circumstances.

In the Court's view, the denial of an employer's right to conduct a reasonable investigation before being compelled to make its decision as to whether to accept or reject the employee's claim can only be justified by evidence of egregious employer misconduct beyond mere failure to provide a claim form to the employee in a timely manner as contemplated by L. C. §5401. Such employer misconduct must, in order to justify application of the doctrine of estoppel, rise to the level of either 1) a deliberate or intentional refusal to provide the required claim form to the employee or 2) false statements made to the employee, all for the purpose of preventing or delaying completion and filing of the claim form by the employee. A mere negligent failure to provide a timely claim form is not sufficient.

By making such distinction, the Court did not mean to indicate that a negligent failure to meet the statutory requirements should be without consequences. Administrative sanctions, however, rather than a loss of a reasonable opportunity to investigate the employee's claim is more appropriate.

The Court could not determine from the record before them whether Honeywell's conduct falls into the egregious category or merely a negligent omission. Therefore, the Court remanded the matter for further proceedings before the WCAB.

VII Res Judicata and Collateral Estoppel

Mendez v. Highlands Insurance Company, (2002) 30 CWCR 252 (Board Panel Decision).

Applicant filed an Application for Adjudication of Claim for a cumulative trauma injury to his head, limbs, spine, and internal organs while employed as a copper plater. The claim went to trial for two days, and the WCJ found that the injury did not occur in and arise out of employment. The applicant died, and his widow sought reconsideration of the judge's Findings and Order. Reconsideration was denied. The widow then, individually and on behalf of their son, filed an Application for Adjudication of their claim of death benefits based on the same allegations as the prior continuous trauma claim. The WCJ dismissed the application, finding that there had already been a final judgment that the deceased had not sustained a compensable injury. Applicant petitioned for reconsideration or, in the alternative, removal.

A panel agreed with the WCJ. The panel indicated that collateral estoppel arises when, (1) an issue presented in a subsequent proceeding is identical to an issue litigated and finally determined in a prior proceeding, (2) the party claiming to be estopped was a party or in privity with a party to the prior proceeding, (3) the issue was finally determined on its merits in the prior proceeding, (4) the prior proceeding was a judicial-like adversary proceeding, (5) the prior hearing resolved disputed issues of fact, and (6) the parties to the prior proceeding had an adequate opportunity to litigate. See *Jablonsky v. City of Los Angeles*, (1994) 22 CWCR 133, 23 CWCR 3. Turning to the facts in this case, the panel was persuaded that all elements for collateral estoppel were present. The issues in both claims were the same. The issues presented by the applicant in the claim for death benefits had already been litigated, and a final decision on the merits had been made. The parties to the death claim were in privity with parties to the inter vivos claim.

The facts that led to the WCJ's final decision on the inter vivos case, that the employee did not sustain a compensable injury, cannot now serve as a basis for a death claim. The widow was collaterally estopped to retry the same issue.

The Board panel agreed with the WCJ that the parties in the death claim are in privity with the parties in the prior claim. Petitioner and her son are sufficiently close to the interests of the deceased applicant because their right to recover is inextricably linked to decedent's entitlement to workers' compensation benefits. The panel also rejected the petitioners' claim that the WCJ had failed to comply with L. C. §5313. The Board further indicated that removal was not appropriate in this case because the dismissal order was dispositive of the final rights and liabilities of the parties. Removal was not, therefore, an appropriate remedy. Accordingly, the Petition for Reconsideration was denied, and the Petition for Removal was dismissed.

VIII Earnings; Indemnity Rate Determination

1. Crampton v. W.C.A.B. (2002) (writ denied) 67 CCC 325.

Applicant was paid wages of $308.52 per week. He sought temporary disability indemnity at a rate based on wages and $11.38 per hour contributions to various union trust funds. The WCJ determined temporary disability based on 2/3rd of wages, $205.52 per week. The WCJ found that the moneys contributed to the trust fund were not wages or actual earnings for purposes of determining compensation rate. The WCAB denied reconsideration, and the Court denied applicant's petition for writ of review.

2. Rodeburg v. W.C.A.B. (2002) (writ denied) 67 CCC 198.

Applicant injured both her knees on December 9, 1994. Benefits were furnished and the case led to Findings and Award. On September 25, 1996, applicant injured her spine, and developed injury to her psyche secondary to the back injury. No separate application was filed for the 1996 injury within one year and three months of its occurrence. After trial, the WCJ found that the 1996 case was barred by Labor Code § 5405, but also found that the back and psyche disabilities and need for treatment were compensable consequences of the 1994 injury. He awarded permanent partial disability and life pension at the 1994 injury rates. Applicant filed a petition for reconsideration seeking permanent partial disability and life pension at the rates for the September 1996 compensable consequence injury; applicant's counsel filed a separate Petition for Reconsideration seeking increase in attorney's fees to include value of disputed temporary disability award and life pension. Applicant's authority was Trevino v. WCAB (1989) 207 Cal. App. 3rd 1012; 54 CCC 50; which awarded compensation at the rate of a compensable consequence injury incurred in the course of vocational rehabilitation. The WCJ, in his Report and Recommendation on Reconsideration, distinguished Trevino and declined to extend that ruling to consequential injuries not occurring during vocational rehabilitation. The WCJ agreed with applicant's attorney's petition. The Board denied applicant's petition and remanded the matter to recompute attorneys fees. Applicant's petition for writ of review was denied.

IX Temporary Disability

City of Sacramento vs. W.C.A.B. (Saylors) (2002) 67 CCC 6.

Applicant injured his back during a training exercise as a “fire recruit” for defendant. The injury was admitted and defendant provided temporary disability benefits. Applicant applied for benefits under Labor Code §4850, which provides for a leave of absence at full salary in lieu of temporary disability payments for public safety employees.

Defendant denied the benefits. It contended that a fire recruit was not a firefighter under that section. The Court of Appeal agreed and overturned the Board’s award of full salary benefits.

Labor Code §4850(b) excludes “employees of the city fire department, county fire department, and of any fire district whose principle duties are those of a telephone

operator, clerk, stenographer, machinist, mechanic, or otherwise, and whose functions do not clearly fall within the scope of active firefighting and prevention service…."

The Court defined "firefighters" as employees of the fire department actively engaged in firefighting and fire prevention services. The city's job description for a fire recruit is one who "attends and participates in the Sacramento Fire Training Academy in order to receive basic training in fire fighting methods, equipment operation, medical aid and physical fitness."

The court also looked at the recruit's duties, which include classroom instruction and live fire exercises. The court noted that the fire exercises involve a closely controlled live fire in an empty brick building. It further noted that the recruits are not exposed to the same risks as "firefighters."

X Medical Treatment / Presumption of Correctness of Primary Treating Physician

1. *Butterball Turkey Co. v. W.C.A.B. (Dickinson)* (2002) (writ denied) 67 CCC 86.

Applicant sustained an admitted injury to both knees on 1/2/98, while working for defendant. Defendant provided benefits. Later, applicant further claimed that she had injured her anterior cruciate ligament (ACL). Defendant denied injury to the ACL.

Applicant was examined by AME Dr. David Chittenden, who opined that applicant's ACL injury was not industrial. However, in his deposition the AME noted that the surgery included debridement of the patella and an ACL reconstruction. He further indicated that from a billing standpoint these were not separate and distinct procedures. He went on to explain that the ACL was in a weakened state, and that it was reasonable to treat the ACL because without the treatment, a fall would cause further problems.

At trial the WCJ found no injury to the ACL based upon the opinion of the AME. The WCJ further found that defendant was not responsible for the ACL surgery. Applicant filed a Petition for Reconsideration, contending: (1) the accepted injury was to the knee which should include the whole knee; and (2) the ACL was compensable. Defendant also filed a Petition for Reconsideration on other issues.

The WCJ recommended that the Petition for Reconsideration be denied. He indicated that there was no credible evidence showing a relationship between her industrial injury and her ACL. Likewise, he found that liability for the ACL injury under the theory that a defendant is liable for non-industrial treatment if it is required as a component of the industrial treatment, as set forth in Granado v WCAB (1968) 33 CCC 647, was not proven by applicant.

The WCAB granted reconsideration and remanded the decision to include a specific finding that the surgery to repair the ACL was compensable. The Board relied upon the AME's deposition testimony that the ACL reconstruction was inextricably linked to the patella repair. Consequently, the ACL surgery was compensable.

2. *Herbers v. Traveler's Insurance Company*, (2002) 30 CWCR 218 (Board Panel Decision).

Applicant was employed as a field generalist by California State Automobile Association. The Applicant saw Dr. Kindall, complaining of pain in her neck and both arms as a result of a change in her workstation. Dr. Kindall treated the Applicant and then confessed an inability to explain why the pain had not been abated after she had been off work for a considerable period of time.

In his final report, Dr. Kindall said he had no further treatment to offer Applicant and referred her to a rheumatologist, who reported that a trigger-point injection had given her no relief.

The Applicant chose Frederick Herman, M.D., to be her primary treating physician. Dr. Herman began treatment and submitted numerous prescription slips and progress report forms giving a diagnosis of chronic fatigue syndrome and fibromyalgia. In a two-paragraph report, Dr. Herman wrote that Applicant's onset of fibromyalgia was directly related to her change in workstation.

Applicant filed an application claiming she suffered cumulative injury to her neck and arm. In response, Defendants arranged for her to be evaluated by Dr. Riemer, as a qualified medical evaluator in neurology. Dr. Riemer reported a normal physical examination and made a diagnosis of nonspecific brachial and low-back pain syndrome. He found that she did not meet the standard criteria for fibromyalgia. The doctor rejected the diagnosis of overuse syndrome. Dr. Riemer wrote that Applicant's subjective complaints exceeded the objective findings. The matter proceeded to hearing.

The medical reports were received into evidence, and the Applicant testified. The WCJ found that Applicant had sustained a cumulative injury which caused a 3% permanent disability, and a need for medical treatment, but the injury did not cause fibromyalgia.

Applicant sought reconsideration contending that Dr. Riemer's report was not substantial evidence and that Dr. Herman's report was entitled to L. C. § 4062.9 presumption of correctness. The Applicant argued that if the Board did not consider the medical evidence adequate, the record should have been further developed.

The WCJ in his report and recommendation for reconsideration stated that the Applicant's testimony was found not to be credible. The WCJ did not accept the opinion of Dr. Herman who neither gave a correct history nor made a connection between the work and the disability.

The WCJ found Dr. Riemer's report to be sufficient for determination of the issues raised. A WCAB Panel concluded the WCJ had reached the correct result. The Panel indicated that L.C.§4062.9 provides that when an additional comprehensive medical evaluation is obtained under L.C.§ 4061, the findings of the primary treating doctor are presumed correct.

The presumption is rebuttable and may be controverted by a preponderance of medical opinion indicating a different level of impairment. The presumption is one that affects the burden of proof, and any argument that the QME's evaluation is more thorough than the PTP's must be made in the context of the mandates of WCAB Rule §10606. See *Minniear v. Mount San Antonio Community College*, (1996) 24 CWCR 261, 61 CCC 1055.

Among other things, Rule 10606 requires medical reports to have a history of injury, the patient's complaints, and his or her medical history. The presumption has been held to have been rebutted when the primary treating physician did not have a complete history, the Applicant lacked credibility, and the objective disability factors were lacking. *Mejia v. WCAB*, (2000) 65 CCC 942 (writ denied).

The presumption has also been held to be rebutted where the factors of disability are inconsistent with the Applicant's testimony (*Manning v. WCAB*, (1998) 63 CCC 1292 (writ denied)), where the primary treating doctor's reports were not substantial evidence, but the QME's were. *Badigan v. WCAB* (1998) 63 CCC 1053 (writ denied). And where the primary treating physician did not explain how he determined the PD factors, and the Applicant was not credible. *Uboldi v. WCAB*, (1998) 63 CCC 1328 (writ denied).

To be substantial evidence, the Panel concluded, medical opinion may not be based on surmise, speculation, conjecture, guess, incorrect legal theory, incomplete or erroneous history, inadequate examination or facts that are no longer germane. The doctor must give a solid and reasonable basis for his conclusions, and the Board may not rely on a medical report that lacks a sound underlying basis. If the facts on which the physician relies lack probative value, his or her conclusions do also.

The Panel then indicated that in applying these principles to the case before them, they were persuaded that Dr. Herman's report did not constitute substantial evidence. The Panel explained that most of the reports were simply prescription forms with no history, and contained only sparse conclusionary information about his findings.

Applicant's complaints were offered without empirical corroboration. None of the reports demonstrated that the primary treating physician examined Applicant for the key signs of fibromyalgia, or questioned her regarding the constellation of symptoms usually associated with a diagnosis. The report of January 25, 2002 discussed the etiology of Applicant's condition. The report, however, not only contained a flawed and inaccurate history, but it lacked any record review.

The Panel explained that Dr. Riemer's reports were substantial evidence. He reviewed the entire medical record and Applicant's deposition. He performed two thorough physical examinations that were both essentially negative. The history that he recorded was more consistent with Applicant's testimony than that on which Dr. Herman relied.

Dr. Riemer's conclusions were well-reasoned and supported by the clinical data. The Board concluded that Dr. Riemer's report rebutted the presumption of correctness of the

primary treating doctor's reports which were deficient. The Board concluded there was no basis to further develop the record, and reconsideration was denied.

2. *Insurance Co. of the State of Pennsylvania v. WCAB (Rollins)* (2002) (writ denied) 67 CCC 470.

Applicant injured her lumbar spine on 6/30/99 while working as an expediter for defendant. In an F&A the WCJ awarded TTD from 7/22/99 through 9/21/00 and further medical treatment, including a supervised weight loss program. The WCJ found that applicant was P&S as of 9/21/00. The WCJ concluded that the opinions of the treating physician did not constitute substantial evidence.

Applicant sought reconsideration, contending that she was entitled to TTD from 9/22/00 to present and continuing, while she participated in the weight loss program; and that the Labor Code § 4062.9 presumption was not rebutted by reports from the defense QME.

The WCJ reasoned that receiving treatment was not necessarily inconsistent with a finding of being permanent and stationary. Applicant testified that her condition had not changed for over a year and that without a weight loss program and exercise (which she could not do) her capacity to reduce her weight from 260 pounds to 190 pounds would require an inordinate period of time. The WCJ concluded that the treating doctor must explain why applicant would be TTD for more than 2 years, and because he failed to do so, his opinion was not substantial evidence.

The WCAB granted reconsideration and amended the F&A and found that applicant was not P&S and was entitled to TTD, that the Labor Code §4062.9 presumption applied and that the conclusion of the WCJ was speculative. Defendant's Petition for Writ of Review was denied.

4. *Reliance National Insurance Corp. v. WCAB* (Singleton)(2002) 67CCC 1114 (unpublished).

Applicant, a minivan driver for L.A. Taxi System (System), injured her right ring finger on 2/11/00 while unloading a passenger in a wheelchair. System referred applicant for treatment by Dr. Volpicelli. The doctor issued his first report on 2/13/00 indicating a finger sprain. On 3/2/00 the doctor reexamined the applicant and issued a one page report, form PR-2, that applicant was discharged from treatment and released to work without any restriction or permanent disability.

On 3/22/00 applicant retained an attorney. On the same day the attorney sent an appointment letter with Ira Reinherz, D.C., for evaluation, or treatment if necessary. A copy of the letter was sent to the employer, but not the claims administrator, Intercare.

Allegedly, in another letter to Intercare, on the same day, the attorney objected to all previous treating doctors, requested a change of physicians per L. C. §4601, and selected Dr. Reinherz as the treating doctor.

On 3/23/00 Dr. Reinherz examined applicant and prepared a report concluding, among other things, that applicant was in need of further treatment and should be continued on light duty. The report contained a summary of the discharge report issued by Dr. Volpicelli.

On 12/11/00 applicant entered into a Stipulated Award which included a recognition that temporary disability was paid from 2/15/00 through 2/24/00, and that there was no permanent disability or need for medical treatment based upon the opinion of Dr Volpicelli, and that the reports of Dr. Reinherz were procured in violation of L. C. §§4061 and 4062. Applicant further entered into a Compromise and Release in the sum of $1,000.00. Both agreements were approved by the WCJ.

Thereafter, the parties were unable to resolve the lien of Dr. Reinherz, and it was tried. Applicant testified that she informed Dr. Volpicelli that her hand hurt and was swollen to the elbow. She also testified that the treatment by Dr. Reinherz was of benefit, and that the treatment by Dr. Volpicelli was not.

Defendant contended that the examination and treatment by Dr. Reinherz violated L. C. §§4061 and 4062; applicant's letter, with objections, was unsigned and suspect; and that the parties were bound by the terms of the settlement agreement.

The WCJ found that the parties were bound by the terms of the settlement agreements, specifically that there had been violation of the Labor Code. The WCJ rejected the letter because it was unsigned and because there was no offer of an AME, and the attorney did not wait the requisite time. The WCJ found that Intercare had properly objected to the transfer of treatment to Dr. Reinherz.

The WCAB, on reconsideration, overturned the decision of the WCJ. The Board held that there was no proof that the final report of Dr. Volpicelli had been served and that the procedures of L. C. § 4062 begin with receipt of the report. In addition, applicant understood that she could return for treatment if necessary. The case was remanded to the WCJ to determine whether the treatment and billing was reasonable. Defendant appealed.

The court of appeal held that the court must look at the status of the case at the time applicant wants to change physicians. If applicant has been discharged without the current need for treatment; and that fact has been communicated to applicant (or his/her attorney); then applicant cannot elect a new treating doctor without going through the procedures set forth in L. C. §§4061 and 4062.

Here, applicant testified that she was told by Dr. Volpicelli that she could return for treatment, if needed; and the notice sent by Intercare discussed the procedures for disagreeing with permanent disability, but not medical treatment. The court noted that this may be inconsistent with the 3/23/00 report of Dr Reinherz that reviewed the discharge report of Dr. Volpicelli.

The court of appeal remanded the case back to the trial court to determine whether the discharge report of Dr. Volpicelli was served before of after applicant's election of Dr. Reinherz.

5. Gee v. W.C.A.B. (2002) 67 CCC 236.

The applicant initially sought treatment for her upper extremity and wrist injuries with Dr. Nichols in December 1996. On January 6, 1998, Dr. Nichols declared the applicant permanent and stationary. The applicant's condition deteriorated over the next month, and she returned to see Dr. Nichols. The doctor recommended that the applicant visit a QME to determine whether her new symptoms were industrially related. The applicant was, at this time, unrepresented. Following the procedures for an unrepresented injured worker, the applicant selected Dr. Rhoades as her QME from a panel of three physicians offered by the Industrial Medical Council. Dr. Rhoades, on April 23, 1998, acting as a QME, concluded the applicant was not yet permanent and stationary and required additional medical attention. Over the next two years, the applicant continued to treat with Dr. Rhoades and apparently designated him as her treating physician.

Applicant subsequently retained counsel. The applicant was then examined by Dr. Bray as a defense QME. Dr. Bray prepared a report February 14, 2000 concluding the applicant suffered a cumulative trauma injury to her wrists through November 1996 and a second mild cumulative trauma injury to her neck and shoulders through February 17, 1998. Dr. Bray found no indication the applicant sustained a specific injury in February 1998. The parties were unable to resolve the claim, and defendants filed a Declaration of Readiness to Proceed.

In September 2000 the matter came up for mandatory settlement conference and the parties set forth the relevant issues in a pretrial conference statement. The statement did not refer to the treating physician's presumption, but indicated, "The primary treating physician is disputed. Applicant claims Dr. Rhoades." Defendant also objected to admitting Dr. Rhoades' medical reports, claiming he inappropriately treated the applicant after first serving as a QME. The matter proceeded to trial in November 2000.

According to the WCJ, the parties never referred to the treating physician's presumption or to L. C. §4062.9. However, the WCJ's summary of trial evidence again states, "The identity of the primary treating physician is disputed, applicant claiming Dr. Rhoades."

In March of 2001, the WCJ found the applicant properly exercised her right to select Dr. Rhoades as her primary treating physician, despite the former designation as her QME. The WCJ, without referring to the treating doctor's presumption of correctness, concluded that the defense QME was more credible, reasonable, and persuasive than Dr. Rhoades. Accordingly, the WCJ adopted Dr. Bray's conclusions. The WCJ awarded the applicant compensation and penalties in accordance with that QME report.

The applicant petitioned for reconsideration, claiming the judge failed to apply the treating physician presumption of correctness to Dr. Rhoades' medical conclusions. The WCJ explained in his report and recommendation on reconsideration that the

presumption did not apply because L. C. §4062.9 had not been raised as an express issue either at the MSC or the trial, but suggested he might have reached different findings of fact had he applied the presumption. The WCAB adopted the WCJ's reasoning as its own and denied reconsideration.

A petition for writ of review was filed. The Court of Appeal first dealt with the issue that the presumption had not been raised at either the MSC or trial and, therefore, was waived. The Court turned to the case of *Davis v. Interim Health* (2000) 65 CCC 1039 (en banc) which deals with this issue. In *Davis*, a WCJ refused to apply the treating physician presumption which was raised for the first time at trial. On reconsideration, the injured employee argued she timely raised the presumption, and that as a statutory provision, the presumption need never be raised as a separate issue. The WCAB found the presumption may properly be raised up to the time of trial and remanded the case to the WCJ to consider the issue in light of the presumption. The WCAB also concluded that in the interest of judicial economy, the L. C. §4062.9 presumption must be raised as a separate issue. The WCAB found its conclusion consistent with the purpose of L. C. §5502(d)(3), that issues are set forth and resolved as expeditiously as possible.

In this case the WCAB concluded that, under *Davis*, the treating physician's presumption did not apply to Dr. Rhoades' medical diagnosis because the applicant untimely raised the presumption as a separate issue. The Court, however, indicated that they disagreed with the *Davis* decision and rejected its application to this case. The Court of Appeal pointed out a presumption is an assumption of fact that the law requires to be made from another fact, or group of facts, found, or otherwise established, in the action.

As correctly articulated in *Davis*, a presumption becomes operative at a trial when the basic facts giving rise to the presumption are established by the pleadings, by stipulation, by judicial notice, or by evidence. A presumption is either conclusive or rebuttable. Every rebuttable presumption is either a presumption affecting the burden of producing evidence or a presumption affecting the burden of proof.

A presumption affecting the burden of producing evidence requires that the ultimate fact be found from proof of the predicate facts in the absence of other evidence. If contrary evidence is introduced, then the presumption has no further effect and the matter must be determined on the evidence presented. A presumption affecting the burden of proof has a more substantial impact in determining the outcome of the litigation. The effect of a presumption affecting the burden of proof is to impose upon the party against whom it operates the burden of proof as to the nonexistence of the presumed facts (Evidence Code §606).

The Court concluded that the presumption of L. C. §4062.9 was intended to affect the burden of proof because it was part of an effort by the legislature to implement a public policy of reducing medical-legal costs and expediting resolution of medically related issues by restricting the number of medical evaluations. Accordingly, the treating physician's presumption imposes, upon a party against whom it operates, the burden of proof as to the nonexistence of the presumed facts.

The Court went on to state that although the WCAB is not required to follow common law or statutory laws regarding the admission of evidence, it must adhere to the same rules of judicial notice applicable to the courts of record. One such rule mandates that the WCAB take judicial notice of all federal and state decisional, constitutional, and statutory laws. The WCAB must therefore take judicial notice of L. C. §4062.9.

Accordingly, the WCAB's consideration of the presumption is mandatory and not dependent upon whether a party timely raises the provision as an issue. Whenever the presumption's underlying conditions are established by the pleadings, stipulations, judicial notice, or evidence, the trier of fact must adopt the initial assumption that the treating physician's medical diagnosis is correct.

Under the terms of L. C. § 4062.9, the presumption of correctness applies by operation of law to the primary treating physician's findings when: One, an additional comprehensive medical evaluation is obtained under L. C. §§4061 or 4062; and, two, both parties do not select a qualified medical examiner. As a rebuttable presumption the treating physician's diagnosis may be controverted by a preponderance of medical opinion indicating a different level of impairment.

The parties did not dispute whether an additional comprehensive medical evaluation was obtained under L. C. §§4061 or 4062. However, the WCAB now contends the treating physician's presumption never arose because both the applicant and defendant selected QMEs. The facts of this case establish that Dr. Nichols treated the applicant between December 1996 and January 1998. Following Nichols' suggestion to seek the opinion of a specialist, the applicant selected Dr. Rhoades to serve as her QME and to continue to serve as her treating physician. Defendants subsequently got their own QME, Dr. Bray, to evaluate the applicant. The WCAB contends the treating physician presumption does not apply under its own terms because both parties selected a QME.

The Court of Appeal disagreed with this interpretation. The Court stated that under L. C. §4062.9, the findings of the treating physician are assumed correct. Although L. C. §4062.9 does not address the factual situation presented here, where more than one physician treats an injured worker, the workers' compensation system contemplates only one primary treating physician's medical report. L. C. §4061.5 provides that the treating physician, primarily responsible for managing the care of the injured worker or the physician designated by that treating physician, render opinions on all medical issues necessary to determine eligibility for compensation. In the event there is more than one treating physician, single reports shall be prepared by the physician primarily responsible for managing the injured worker's care which incorporates the findings of the various treating doctors.

The Court pointed out that the WCJ expressly found that Dr. Rhoades served as the primary treating physician because no evidence demonstrated Dr. Rhoades improperly solicited the applicant as a patient or accepted a thing of value in violation of L. C. §139.2(o). The WCJ also relied on the IMC notice sent to every injured worker in the state who selects a QME, which provides: "A QME may not offer or solicit you to become your treating physician. However, you have the right to request the QME to become your treating physician."

The Court pointed out that they find no reason to question the IMC's authority to permit an injured worker to designate a QME as their primary treating physician. Because there may only be one primary treating physician under L. C. §4061.5, the WCJ's finding that Dr. Rhoades served as the primary treating physician trumps any prior treating physician designations. Accordingly, Dr. Nichols was not the treating physician primarily responsible for managing applicant's care and authorized to prepare a single report incorporating the findings of the various treating doctors.

Harmonizing L. C. §§4061.5 and 4062.9, the Court found the treating physician's presumption of correctness only applied to Dr. Rhoades. The Court concluded that Dr. Rhoades' appointment as the primary treating physician cancelled his former designation as a QME for the purposes of applying the treating doctor presumption. Under L. C. §§4061.5 and 4062.9, the treating physician's presumption is barred only if both parties select QMEs to dispute the medical diagnosis of the designated primary treating physician. The Court ruled that, in this case only, one party, the defendant, selected a QME, Dr. Bray, to perform a comprehensive medical evaluation to rebut the conclusions of Dr. Rhoades.

The Court went on to state that they recognized the potential for an injured worker unhappy with the treating physician's diagnosis to select a QME with a more favorable diagnosis as the worker's primary treating physician in order to gain advantage of the L. C. §4062.9 presumption. However, the Court must presume the legislature and the IMC contemplated such a result in adopting the presumption and permitting QMEs to serve as treating physicians.

The Court also stated that they found no significant prejudice to an opponent or inconvenience to the WCAB in not raising the treating physician's presumption as a specific issue during the workers' compensation proceedings. Under L. C. §4062.9, the parties and the trier of fact all have adequate notice of the presumption's applicability whenever the underlying facts are established. However, consistent with the WCAB's goal of facilitating judicial economy, parties should raise any objections to the presumption's underlying factual conditions early in the litigation and no later than trial.

The Court then stated that although they disagreed with *Davis*, under its own reasoning, they would conclude that the treating physician's presumption applied because it was timely raised by the date of trial. Both the pretrial conference statement and the summary of trial evidence indicate the identity of the primary treating physician was in dispute. Thus the question of whether Dr. Rhoades properly served as the primary treating physician was at issue since the beginning of the litigation.

The Court found that once the WCJ determined that Dr. Rhoades served as the primary treating physician and only one party, the defendant, selected a QME to prepare an additional medical evaluation to rebut the primary treating physician's medical findings, the treating physician presumption applied. Accordingly, the WCAB and the WCJ erred by not weighing the medical evidence in light of the presumption. The WCAB decision was annulled and the matter remanded to the WCAB with directions to reconsider the medical evidence by applying the treating physician's presumption under L. C. §4062.9.

6. Withers v. The May Department Stores (2002) 30 CWCR 15 (Board Panel Decision).

Applicant was employed by defendant. Pursuant to L. C. §4600.3, the employer contracted with the health care organization to provide medical services for its injured workers. When applicant was hired by defendant in November 1999, she was notified that she could choose to be treated by a personal physician designated prior to an industrial injury, and she was given the opportunity to name either a health care organization, or a personal physician to treat her if she were injured on the job.

She chose Dr. Yaron and signed a document stating that she did not want to enroll in an HCO, but wanted that doctor to treat her for any work-related injury or illness. Two days after the injury, the applicant requested medical treatment and was sent to a medical center chosen by the defendant.

The applicant then wanted to see another doctor, and apparently defendant did not respond to her satisfaction, so she consulted an attorney who notified the defendant that the applicant was designating Dr. Sobol as her physician of free choice. The attorney also requested defendant to provide a change of physician as provided in L. C. §4601. Defendant promptly replied that they had 365 days of medical control.

Dr. Sobol reported that applicant had been temporarily disabled, and a hearing was requested to resolve the issues of TD, medical treatment, and the identity of the primary treating doctor. At the time of the hearing, the applicant testified that she filled out the form called "Choosing Medical Care for Work-related Injuries and Illness," on which applicant chose Dr. Yaron. This document was received in evidence.

The applicant admitted signing the form and briefly discussing the form with defendant's human resources representative, but denied receiving a brochure explaining the HCO system. The applicant did not know what an HCO was when she was injured. At the time she was injured, she had forgotten about selecting Dr. Yaron and defendant never mentioned it.

Less than a week following the hearing, the WCJ issued a finding that neither party had followed the provisions on the form that applicant had signed and ordered that pursuant to agreement, applicant should be examined by Dr. Yaron. Dr. Yaron notified the parties that he was not qualified to report on the issue in the applicant's case and that she should be seen by an industrial medical professional.

The judge then issued a ruling that since Dr. Yaron will not write a report, it appears that control shifts back to the employer under the rules for an HCO. The defendants can schedule an exam with a Dr. Tooke. The applicant must keep this appointment. In the alternative, the parties can utilize an AME.

Applicant petitioned for reconsideration or removal contending that she opted out of the HCO and cannot be forced back. And because defendant's 180 days of medical control under L. C. §4600.3 (c) has elapsed, she was free to exercise her right to choose her

primary treating physician. Because defendant had not followed the L. C. §§4061/4062 procedures, none of its medical reports were admissible into evidence.

Defendant argued that when a predesignated physician refuses to treat, medical control reverts to the HCO for the remainder of the 140 days. A panel granted reconsideration for study. The panel began by quoting L. C. §4600.3 (a) 1 to the effect that when an insured employer contracts with at least two HCOs for health care services required for industrial injuries, the employee who is subject to the contract will receive medical services in the manner prescribed in the contract. But an employee may choose to be treated by a personal physician, personal chiropractor, or personal acupuncturist that he or she has designated prior to the industrial injury, in which case, the employee shall not be treated by the health care organization. The section provides that every employee must be given a choice at the time of employment, and periodically thereafter, to designate or change the designation of an HCO or personal physician.

Applying the law to the facts of this case, the panel ruled that if the personal physician is unavailable to provide the services for which the predesignation is made, there is no good reason why the injured employee should not be able to select a doctor who can provide the services. The fact the applicant forgot that she had predesignated Dr. Yaron did not restore control of the treatment to the HCO.

The Board concluded that the applicant was now entitled to choose another physician to treat her injury. The panel cautioned that an employee who predesignates a personal physician must first go to that doctor for treatment before exercising the right to free choice. The statute permits changes in the predesignation only before the injury, and the applicant must initially seek treatment from that doctor.

Here the parties attempted to refer the applicant to Dr. Yaron, but he refused to treat the industrial injury. She should, therefore, be entitled to choose a new PTP. The Board vacated the judge's decision and substituted a finding allowing the applicant to change the PTP to a physician of her choice.

XI Medical Legal, QME Process & Other Discovery

Fernandez v. Farmers Insurance Exchange, (2002) 30 CWCR 222 (Board Panel Decision).

Applicant was employed as a housekeeper and baby-sitter. She fell down stairs and injured her right wrist. She saw a Dr. Bashner, who diagnosed a fracture, which he reduced and splinted. He told her that she could return to work that did not require the use of the right arm.

In a supplemental report, the doctor indicated he had applied a long-arm cast, and then wrote that because the employer refused to modify the work to conform to her restrictions, the Applicant was considered temporarily totally disabled. The doctor recommended that she stay in a cast for six weeks, and that her disability would be permanent and stationary in about three months.

At the request of the Defendant, the Applicant was examined by Dr. Lynch who limited her to light work consisting of no lifting of over five pounds with the right hand, no repetitive right-hand activities or forcible gripping, pushing or pulling. He concluded that if such work was unavailable, she would be on temporary disability for four weeks.

Applicant made a claim for temporary disability which was heard by a WCJ. Medical reports were received into evidence. Testimony of the Applicant and the employer was heard.

Applicant testified that with only one arm, she could not do any of her job. She testified she was never offered modified work, but she continued to work for two weeks with the help of her sister and cousin. When she was told, on her last day of work, that she was not doing her job, she replied that she was not feeling well and wanted to go home. She did not say that she was quitting. She received a phone call later that day and was told not to come back.

The employer testified that the Applicant was off work for a week following the injury and on her return was required only to care for the baby. Arrangements were made for others to do the housecleaning. Applicant was rarely left alone with the children for more than an hour or two. On Applicant's last day of work, she telephoned to say that she did not want to work anymore and was quitting.

The employer testified that when the Applicant returned to work and said that she would not clean, they hired a cleaning service. Applicant was able to pick up children with her left arm and use her right hand. On the last day of her job, Applicant was upset because her husband had taken a new job that would require him to be away. She said that she wanted to quit and that she did not want to work that day. Applicant had previously quit two or three times, but returned when offered more money.

The WCJ awarded temporary disability from July 6th through September 18th, and thereafter payment of the continuing award was to be made non-prejudicially pending a report from Steven Brourman, M.D., acting as a court- appointed QME. Decision on all other issues was deferred. The WCJ explained that neither the need for further medical treatment nor Applicant's present disability could be resolved by the current medical record.

Applicant filed a petition for reconsideration contending that there was no need for additional medical evidence. The reports of the primary treating physician and Defendant's medical evaluator established the need for further treatment, and because modified work was not offered, Applicant continued to be temporarily totally disabled.

The Board Panel concluded that the WCJ had not only failed to make the findings on the issues presented, but had not explained why the opinions of Drs. Bashner and Lynch were inadequate. The Panel began by discussing the issue of entitlement to continuing TD. The Board indicated that in order to receive continuing temporary disability, the Applicant had to establish that her disability was not yet permanent and stationary, and

that she had not been offered work within the restrictions imposed by the primary treating physician or Defendant's medical expert.

To be compensable, the temporary impairment must affect the injured worker's earning ability and result in wage loss. TD ceases when the worker is medically able to return to work or the disability becomes permanent and stationary. The Board defined "permanent and stationary" as when the possibility of further improvement has become remote. Before a disability can be found permanent and stationary, all reasonable healing modalities must have been attempted and all reasonable diagnostic testing completed.

The Panel indicated that an Applicant is temporarily disabled if he or she is unable to earn any income while recovering from the effects of the injury. If the worker is able to earn some income, but less than full wages, he or she is temporarily partially disabled *Herrera v. WCAB*, (1969) 34 CCC 382.

If the employer offers work that a temporarily partially disabled worker can do, the worker is expected to take it, and no TD is payable; *Meyers v. IAC (Titsworth)*, (1940) 5 CCC 149. When the work that the injured worker can perform is available and the employee is not working at it for some reason other than the disability, then the wage loss is not a result of the injury and no TD is payable. *Hardware Mutual Casualty Company v. WCAB, (Hargrove)*, (1967) 32 CCC 291.

Applying these principles to the facts of this case, the Board noted that the primary treating hysician's report indicated that Applicant had continuing symptoms and required further diagnostic testing. Its logical conclusion was that Applicant continued to be temporarily disabled and in need of future medical treatment.

Although the Minutes of Hearing showed the Applicant had asserted that Dr. Bashner's reports were entitled to the L. C. § 4062.9 presumption of correctness, the WCJ made no finding on that issue. If those reports were followed, Applicant would be entitled to future medical treatment and continuing TD. Instead, however, the WCJ designated a court-appointed QME to resolve those issues.

It was unclear to the Panel why the WCJ wanted another medical opinion when the Applicant had already been evaluated by Drs. Bashner and Lynch. There was nothing to indicate in the record that the parties had discussed using an agreed medical evaluator, and the preferred procedure for developing an inadequate medical record set forth in *McDuffy v. Los Angeles County Metropolitan Transit Authority*, (2002) 67 CCC 138 (WCAB en banc) was not followed.

If the medical record requires further development, supplemental reports should first be obtained from the physicians who have already reported in the case. If the record is still unsatisfactory, the parties may arrange for an agreed medical evaluator. Preferably, a WCJ should not direct an Applicant to be examined by a physician, unless the record remains inadequate after recourse to an AME.

Turning to the issue of modified work, the Board indicated that evidence of whether modified work was offered, or Applicant quit, or was fired, was contradictory. Although the Applicant testified that none of her duties could be performed with one arm, there was no opinion from either Dr. Bashner or Dr. Lynch on whether the work allegedly offered by the employer was within the restrictions that either of them had imposed.

If Applicant's testimony is believed, and Dr. Bashner's medical opinion followed, she is entitled to TD. If, on the other hand, the employer's testimony is credible, Defendant's obligation to pay TD terminated on the day she quit, but Defendant would still be liable for future medical care. The WCJ made no findings on these issues, although he did write in his report on reconsideration that four days after re-injury, the Applicant returned to work and was given a modified job.

In conclusion, the Panel said that further proceedings were necessary and directed the WCJ to make findings on whether (1) Dr. Bashner's findings are entitled to the L. C. § 4062.9 presumption of correctness, (2) modified work was offered, (3) the modified work offered was appropriate, (4) and whether the Applicant quit or was discharged. If the WCJ persists in his belief that a third medical opinion is warranted, he must explain why supplemental reports from Drs. Bashner and Lynch would not provide an adequate medical record.

The Panel granted reconsideration, rescinded the WCJ findings, and ordered the case returned to the WCJ for further proceedings and a new decision consistent with the Panel's opinion.

XII Liens and Lien Claimants

1. *Euge v. City of Los Angeles,* (2002) (Board panel decision) 30 CWCR 129.

Applicant claimed cumulative trauma injury while employed by the City of Los Angeles. Defendant denied liability. Applicant obtained medical treatment on a self-procured basis. Applicant subsequently died. Applicant's health plan, Blue Cross, paid for the treatment and filed a lien for $326,908.68. Applicant was examined by QME, Alvin Markovitz, M.D., who found the case compensable. QME, Bruce Gillis, M.D., found the case not compensable. The WCJ, on August 21, 2000, issued a Finding & Award finding injury AOE/COE and awarding reimbursement for self-procured medical treatment and allowing the lien of Blue Cross. Ninety-three days later defendant paid lien claimant the amount of its lien plus interest for 93 days. Lien claimant petitioned for multiple penalties.

The matter came to hearing before the WCJ on lien claimant's petition. On July 23, 2001, the WCJ found that the defendant unreasonably delayed payment of the August 21, 2000 award and pre-award interest on lien claimant's billing. In addition to 10 percent increases in the award of these delays, the WCJ ordered the amount of lien claimant's billing increased by 10 percent pursuant to L. C. § 4603.2(b), plus interest, beginning on

the 61st day after receipt of the billing. He denied the remainder of the penalty claims. Both lien claimant and defendant petitioned for reconsideration.
Reconsideration was granted for further study, and after deliberation, the WCAB concluded the WCJ had reached the correct result.

The panel first looked at defendant's contention that L. C. § 4603.2(b) applies only to treating physicians and persons who actually provide medical services rather than persons who pay for the treatment. The panel quoted L. C. § 4603.2(b) to the effect that payment for medical treatment must be made by the employer within 60 days after receipt of each billing. If the billing, or a portion thereof is contested, the physician must be so notified within 30 working days. Any properly documented amount not paid within the 60-day period shall be increased by 10 percent, together with interest, retroactive to the date of the receipt of the bill, unless the employer (1) pays the uncontested amount within 60 days, and (2) advises the "physician" or "other provider" of the item being contested, the reasons thereof, and the remedies available to the "physician" or the "other provider" if he or she disagrees. If the employer contests all or part of the billing, any amount determined payable by the WCJ shall bear interest from the date the amount was due until paid. An employer's liability to a physician or another provider for delayed payment does not affect its liability to an employee under L. C. § 5814.

The panel concluded that the section means that when an entity such as Blue Cross undertakes to reimburse a treating physician who provides medical treatment that an employer is refusing to furnish to an injured employee, the entity steps into the shoes of the physician with regard to the employer's liability to pay for the treatment. Pursuant to L. C. § 4603.2(b), the employer is required to pay for medical treatment provided or authorized by the treating physician. Here the treatment for which the lien claimant billed was provided or authorized by a treating physician. L. C. § 4603.2(b), moreover, expressly recognizes the existence of recipients of penalty and interest other than the treating physician when it refers to "physician or another provider." The Board also pointed out the California Supreme Court recognized that persons other than physicians are entitled to benefits other under L. C. § 4603.2(b) when it said the 60-day limit on paying medical bills applied to an injured worker's claim of travel expense for medical treatment.

The panel next rejected the defendant's argument that it was not liable for pre-award interest because it had timely objected to the billing, citing the case of *Boehm & Associates v. WCAB* 64 CCC 1350, which held that interest is payable on unpaid medical bills when the employer denies liability and refuses to pay the bill, and interest begins to accrue 60 days after the employer receives the bill even if the claim is ultimately accepted or determined compensable.

The Board then turned to lien claimant's petition for reconsideration. The Board rejected lien claimant's assertions that defendant had unreasonably refused to pay its billings on four earlier occasions. The panel said that defendant's liability was not unequivocally established until the WCJ's August 21, 2000 Finding & Award. Until that award became final, there was a conflict in the medical evidence, and a different conclusion could have been reached based on the opinion of Dr. Gillis.

Finally, the panel rejected lien claimant's contention that L. C. § 4603.2(b) is a self-imposed penalty. The Board pointed out there's nothing in the section to indicate that the penalties are self-assessing. The only penalties subject to self-assessment are those provided in L.C. §4650, which expressly provides that it is to be paid without application.

The Board affirmed the judge's decision.

2. *Hernandez v. Figi Graphics,* (Board Panel Decision) (2002) 30 CWCR 98.

Applicant injured his back on March 10, 2000, in the course of his employment. He chose George Reese, D.C., to be his primary treating physician. Interpreters attended applicant's visits to Dr. Reese for treatment. The defendant objected to the lien claimant's bills and lien claim filed for $5,250. The case was resolved by Compromise and Release except for the issue of the interpreter lien. The hearing was then held on the lien of the interpreter. At that hearing, the office manager testified that she had forwarded the bills for interpreting service to the claims administrator, but no documentary evidence was submitted to support her testimony. Dr. Reese testified that he was not fluent in Spanish, but does have some competence in the language. He did not use an interpreter at every visit by applicant for treatment. He obtained the services of a lien claimant on his own, without authorization from the claims administrator. Members of his staff are fluent in Spanish, and he used them when there was no one there from lien claimant.

After giving the parties time for points and authorities, the judge ruled the defendant was not liable for the lien for interpreting. Applicant and lien claimant filed Petitions for Reconsideration. In his Report and Recommendation on Reconsideration, the WCJ stated that lien claimant had not borne its burden of proving that the services for which it claims reimbursement were reasonable and necessary. L. C. § 4600 requires the employer to provide treatment reasonably required to cure or relieve from the effects of the injury. Whenever the employer, the insurer, the administrative director, the Appeals Board or a WCJ requests an injured worker to be examined and the employee does not proficiently speak or understand English, the employee is entitled to the services of a qualified interpreter at the employer's expense in accordance with the A.D. rules. Lien claimant had not produced any evidence to substantiate that its services were reasonably necessary. The evidence established that Dr. Reese had competent bilingual personnel in his office who were capable of interpreting for the applicant. Dr. Reese was able to treat applicant competently with his limited Spanish and the aid of bilingual members of his staff. In the opinion of the judge, there was no necessity for calling in outside interpreting services. Neither L. C. § 4600 nor A.D. Rule §9795.3 provide for interpreters at other than medical-legal evaluations, an examination requested by a claims administrator, the A.D. or the WCAB. The WCJ did not believe that A.D. Rule §9795.3 (a)(7) applied to the facts before him. That section refers to the use of interpreters at other similar settings determined by the WCAB to be reasonable and necessary to determine the validity and extent of injury to an employee. The WCJ indicated that, although it is not clear what is contemplated by the word "setting," the term usually refers to some WCAB proceeding such as a conference or a hearing. In the

opinion of the WCJ, it did not contemplate treatment in the primary treating doctor's office.

The WCJ also rejected lien claimant's equal protection argument and estoppel argument. Finally, the WCJ said the applicant had not been denied adequate medical treatment by the decision under attack. He was able to obtain competent chiropractic care without the use of an interpreter.

The Board panel adopted the WCJ's reasoning but added that the facts in *Garcia v. State Fund,* 29 CWCR 310, relied on by lien claimant in a supplemental petition were not the same as those in the case before the Board. The burden of proof under L. C. §5705 establishing that interpreter services are reasonable and necessary is on the lien claimant. The Board indicated the burden was not sustained in this case. Dr. Reese testified that he did not use an interpreter at every visit. There was no mention of the use of an interpreter in his reports. There was no evidence presented regarding applicant's proficiency in English or the qualifications of the interpreter as provided by lien claimant. The panel denied reconsideration.

3. *Herrera v. Kemper Insurance*, (2002) 30 CWCR 278 (Board Panel Decision).

Applicant injured his knee in the course of his employment. Surgery on the injured knee was performed at the San Jose Outpatient Surgical Facility. When the employer's insurer paid only a portion of the bill, the surgery center filed a lien for the balance. The matter then came to hearing on the reasonableness and necessity of the lien. The Minutes of Hearing showed no stipulations or issues as being recorded. Trial briefs were noted to be submitted. Documents were attached, but there was no indication whether any had been received in evidence. A decision followed allowing the lien in the amount of $4500. In his Opinion on Decision, the WCJ wrote that a standard controlling the reasonable value of outpatient fees did not exist, but $4500 was a reasonable compromise after considering arguments of both parties.

Lien claimant petitioned for reconsideration contending that (1) the correct standard for determining the reasonable value of its services was whether they were usual and customary and comparable to those of similar providers in the same area, and (2) the WCJ's finding was not justified because the lien amount was less than the usual fees charged by similar providers in San Jose. On October 13, the WCJ filed an order vacating his decision. At the outset of its opinion, the Panel observed that the WCJ's purported order vacating his decision was invalid and void *ab initio*. WCAB Rule §10859 provides that a WCJ may rescind the decision under attack within 15 days following the filing of a Petition for Reconsideration. Because lien claimant's petition was filed on July 22nd, the judge was precluded from amending, modifying or rescinding it after August 6th.

The Panel, however, agreed that the order had to be rescinded. The WCJ's declaration that allowing the lien in the amount of $4500 was a reasonable compromise, after considering the arguments of both parties, was merely a conclusionary statement and did not explain the grounds on which the determination was made as required by L. C. §5313. The import of the WCJ's statement that there was no existing standard

controlling the reasonable value of outpatient facility fees was not clear. The Panel explained that the official medical fee schedule applies to all covered medical services provided regardless of the type of facility in which they were performed. The reasonable value of fees for those services is ordinarily determined by reference to the official medical fee schedule. If the provider of such services claims a fee in excess of that provided in the official medical fee schedule, the provider must accompany the claim by an itemization and justify the excess by an explanation of extraordinary circumstance related to the unusual nature of the services rendered. In no event, however, may a physician charge in excess of his or her usual fee. On the other hand, the Panel continued, the official medical fee schedule does not apply to facility fees for the use of the emergency room or operating room or an ambulatory surgical center or surgical clinic. The charge must, however, be reasonable. In determining the reasonable value of such charges, the WCAB takes into consideration a number of factors. Among them is the fee usually charged in the geographical area where the service is provided. Therefore, standards were in existence for determining the reasonable value of the services for which lien claimant billed.

In conclusion, the Panel noted that the record before it did not meet the minimum requirements as set forth in *Hamilton v. Wausau Ins. Co.* (2001) 66 CCC 473 (WCAB En Banc) by having a proper record to decide a case. Accordingly, the Panel granted reconsideration and rescinded the decision and remanded the matter for further proceedings consistent with its decision.

4. *PM&R Associates v. WCAB (Zavala)* (2002) (writ denied) 67 CCC 485.

PM&R was a medical practice that provided physical therapy services for patients suffering from industrial and non-industrial injuries. The doctors there hired and trained unlicensed medical assistants to perform physical therapy modalities upon patients. Several patients would arrive at the same time. The physicians were not usually in the therapy rooms, but were in the office. There were some visits when only the medical assistants saw the patients. The medical assistants would perform services based upon written instructions, and could obtain assistance from the physicians, if necessary. The records identified the modality performed, but not the name of the medical assistant that performed the therapy.

Zurich Insurance Company denied payment to PM&R on the ground that the medical services rendered were provided by unlicensed medical assistants. The consolidated cases went to trial and ultimately came before the Fifth District Court of Appeal. After remand to the WCAB for further proceedings, the WCAB issued an Opinion and Decision After Remittitur stating that the trial court was to consider whether the training, supervision and care provided by medical assistants complied with the requisite standards.

The matter proceeded to a second trial, after which the WCJ issued a decision concluding that: (1) each supportive service performed was lawful and customary to the medical

practice, (2) the supervising physician authorized the medical assistant to perform the services and maintained responsibility for the patients' treatment and care; and (3) the medical assistants had completed sufficient on-the-job training to demonstrate competence. However, the WCJ further concluded that improper billing codes were used, since there was no way to determine the value of the services performed under the California Medical Assistants Act.

PM&R filed for reconsideration, challenging, in relevant part, the WCJ's findings regarding its documentation of services performed and billing practices. The WCJ recommended denial of the Petition for Reconsideration. The WCJ reasoned that PM&R was holding itself out as providing physical therapy, it was billing for physical therapy, yet it was using unlicensed medical assistants. The WCJ reasoned that the Fee Schedule does not apply, and the liens are not reimbursable as submitted because improper billing codes were used. The WCAB adopted and incorporated the WCJ's report and denied reconsideration.

PM&R filed a Petition for Writ of Review, contending, in pertinent part, that: (1) the WCAB erred in holding the fee schedule was inapplicable and that lien claimant was using improper codes; (2) the WCAB erred in ruling there was inadequate documentation of the services rendered; and (3) the WCAB erred in denying the lien claims when the only issue was reimbursement for medical assistants' services. The Writ was denied. However, the Court of Appeal noted that the WCAB had erred in concluding services by unlicensed medical assistants are not reimbursable under the workers' compensation system, citing the earlier decision in this case. The WCAB also erred by instructing lien claimant to demonstrate that its medical assistants were not practicing physical therapy. This issue had also been decided in the previous decision.

Nevertheless, the Court did deny the writ because the WCAB's finding that PM&R failed to comply with the record-keeping requirements of California Code of Regulations §1366(a)(4), is supported by the evidence. The Court had specifically asked the WCAB to determine whether the lien claimant complied with the provisions of Business and Professions Code §2069 and the attendant regulations governing medical assistants.

XIII Vocational Rehabilitation

1. *Jack in the Box v. WCAB (Morrison)* (Filed January 3, 2003) Court of Appeal, First Appellate District (not to be published) 68 CCC _____ .

Applicant injured his low back while working as a clerk on July 16, 1998. The Applicant filed an Application to adjudicate his claim on August 27, 1999. Applicant was injured in California, but moved to Great Falls, Montana at some time prior to the filing of the Application. The WCJ issued a Findings and Award finding applicant was entitled to reimbursement for certain medical expenses, further medical treatment and temporary disability benefits from July 17, 1998 to July 28, 1998, and again from June 14, 1999, to present. On January 16, 2001, applicant underwent a lumbar discetomy. Dr. Peterson, a Montana physician, who was referred to the applicant by his surgeon, gave an assessment of his disability, concluding that applicant could return to work subject to restrictions that included no sitting for more than 30 minutes without a

break, no prolonged walking or standing for more than 30 minutes without a break, no repetitive bending, stooping or twisting, no squatting, kneeling or crawling, and no work with arms above head. Applicant can do sedentary work involving lifting ten pounds maximum and occasionally lifting or carrying up to five pounds with frequent stretch breaks at least once every 30 minutes.

Applicant subsequently submitted a request to the R.U. for rehab services. About two weeks later, the employer sent Applicant a form notice of offer of modified or alternative work dated July 31, 2001. This notice offered applicant a job described as guest-service cashier. In a letter dated August 6, 2001, Applicant requested the R.U. to determine that employer's R.U. 94 job offer was inappropriate due to lack of clarification of the job title being offered and physical requirements of the job being offered. The R.U., in a determination dated August 29, 2001, found Applicant was eligible for rehab services and directed him to submit a proposed plan for receiving these services out of state.

The employer filed an appeal. The employer argued that the R.U. Determination had not taken into consideration the employer's offer of modified or alternative work which precluded any liability for rehab services. The WCJ held a hearing on this appeal to determine the sole issue of whether this employer's job offer met the statutory requirements of L. C. §4644. The matter was submitted on the basis of exhibits that included the employer's offer of work, medical reports of Dr. Peterson, and the R.U.'s Determination. Additionally, applicant submitted an offer of proof, that to his knowledge, there was no job available at the employer's fast food restaurant that he could perform within the restrictions set forth by Dr. Peterson, and it was not feasible for the employer to modify an available job to conform to these restrictions. On March 21, 2002, the WCJ issued a Findings of Fact and Order ruling the employer had not made a *bona fide* offer of modified or alternative work. Employer filed a Petition for Reconsideration which was denied by the Appeals Board. A writ review was then filed. The issue before the Court of Appeal was one of law, whether the Board correctly interpreted and applied L. C. §4644 when it determined that the employer had not made an effective offer of modified or alternative work. The court went on to state that L. C. §4644 generally sets limits on vocational rehab services available to injured workers under the California workers' compensation law. Subdivision (a) provides that an employer's liability for these service terminates in a number of specified circumstances. One of these, set out in L. C. §4644(a)(5) and (6), is the situation in which an injured worker accepts or rejects an employer's offer of modified or alternative work. If the employer in this case made an effective offer under subdivision (a)(5) and (6), applicant's rejection of the offer operated to terminate the employer's obligation to provide vocational rehab services to the Applicant. The employer made its offer to applicant by completing DWC form RU 94, a notice of offer of modified or alternative work. The DWC's administrative rules require the use of this form to make an offer under L. C. §4644(a)(5)and (6). The completed form offered a job described as that of a guest-services cashier, but provided no other details about the job. The form was attached to a cover letter advising Applicant that the offer was for modified or alternative work within the restrictions imposed by his new treating physician, Dr. Peterson. Also attached was a completed DWC form RU 91, description of employee's job duties. The latter form described the title of the offered job as “general production”. It did not provide details of the job responsibilities, but described job activities, exclusively in terms of the physical work restrictions imposed by Dr. Peterson. For example, it described the offered job as one that would involve no repetitive bending, stooping or twisting.

The WCJ determined this was not a *bona fide* offer and thus had no effect on the R.U.'s determination that applicant was eligible for rehab services. The WCJ reasoned that, although the employer made the offer by means of a completed DWC form RU 94, neither this form, nor the accompanying documents provided an adequate job description or information indicating the duration of the offered job and whether it was a regular position. Applicant therefore was in no position to know what he was accepting or rejecting. The WCJ concluded that in order for an offer of work to be *bona fide* under L. C. §4644 (a)(5) or (6), it must identify the job title, provide at least a general job description, state how long it is expected to last and if it is an offer of alternative work and whether it is a regular position. Without this information, the employee has no basis for determining whether or not the position is something that he or she is willing or able to perform, much less whether the offer meets the requirements of L. C. §4644. The WCJ recognized the employer has made the offer using a mandatory DWC form RU 94. On this point, the WCJ noted that this form needs to be revised to require further information consistent with L.C. §4644.

In denying the employer's Petition for Reconsideration, a majority of the Board panel discussed this analysis and concurred with its reasoning. One commissioner filed a dissent stating in his opinion that the completed DWC form RU 91, attached to the DWC form RU 94 provided sufficient description of the job by specifying physical requirements consistent with the limitations imposed by Dr. Peterson. This description conflicted with the Applicant's offer of proof which attested that the employer could not feasibly provide a job within the limitations prescribed by Dr. Peterson. It was therefore proper, in the dissenting commissioner's opinion, to rescind the decision of the WCJ and remand the matter for a new decision following further development of the record in order to resolve the conflict.

The employer takes the position that its cover letter, the completed DWC form RU 94, and the completed DWC form RU 91 together satisfy the requirements of an offer of modified or alternative work under L. C. §4644(a)(5) and (6). Employer argues Applicant has the burden of showing he was entitled to rehabilitation services because the offer failed to satisfy L. C. §4644. According to the employer, it was the Applicant's responsibility to contact the supervisor listed on the DWC form RU 94 in order to obtain additional information. He may have needed to determine whether the offer was *bona fide*. The Court noted that the WCJ's use of the term "*bona fide*" derives from Rule §10126, which generally requires an injured worker to accept or reject a *bona fide* offer within 30 days. Reference to other language in Rule §10126 indicates that for purposes of its procedural requirements, a *bona fide* offer is nothing more or less than an offer that meets the criteria of L.C. §4644 (a)(5) and (6).

In any event, the effectiveness of an offer of modified or alternative work depends on the requirements of L. C. §4644. The use of the term "*bona fide*" in Rule §10126 cannot be construed to impose any requirement that conflicts with, adds to or detracts from the requirement set out in the enabling legislation.

The Court then said they would proceed to examine the requirements of L. C. §4644. The plain language of L. C. §4644 indicates an intent to limit the employer's liability for vocational rehabilitation costs under specified circumstances. L. C. §4644 was enacted as part of a larger scheme designed to make California a more business friendly environment by reducing workers' compensation costs overall. L. C. §4644 must accordingly be construed to give effect to this

intent, albeit in harmony with the overreaching policy of liberal construction and in favor of the injured employee.

Subdivision (a)(5) and (6) of L. C. §4644, enables the employer to avoid liability for vocational rehabilitation services by offering an injured employee a job in lieu of these services. Nevertheless L. C. §4644 protects the rights of an injured employee by placing some basic restrictions on the job an employer may offer. Thus a job being offered must be available for at least 12 months. It must also be a regular position. Specifically, it must be a position that actually exists and arises from the employer's usual business needs as distinguished from a fictitious position offered with the expectation the employee will reject it or a position created temporarily simply to avoid rehab liability. This requirement applies expressly to alternative work. It also applies to modified work by necessary implication because a modified job is essentially the regular position the employee held previously, but with modifications.

A job being offered must further have compatible compensation. We use the terms "compatible" or "convenience" referring to compensation that is within 15 percent of that which the injured employee earned at the time of his or her injury. The job must also be located within a reasonable commuting distance of the injured employee's residence at the time of injury. These criteria are expressly required for alternative jobs. Again, by implication, they are required as well for modified jobs. A job that is the same as the one the employee previously performed, with modifications, will necessarily be a position with compatible comparable compensation. The same job, with modification, will also typically be in the same location as a previous job. A commute to the location of the previous job may be presumed reasonable since the employee freely made such commute prior to the injury.

The job being offered must be one with physical requirements that the injured employee can reasonably expect to perform. In the case of alternative work, the job is expressly required to have only those essential functions that are within the employee's current performance abilities.

With respect to modified work, any modification, by necessary implication, is one designed specifically to accommodate the injured employee's current performance abilities. The Court concluded that an offer of modified or alternative work under L.C. §4644(a)(5) or (6) must provide information sufficient to show that the offered job meets the foregoing minimum requirement. The statute allows the employee to accept the offered work or reject it. If the employee rejects it, rehabilitation services will not be available. This choice, in the opinion of the Court of Appeal, becomes meaningless, unless the offer provides information and that allows the employee to make an informed choice.

In the opinion of the Court, an offer of modified or alternative work must include information describing jobs responsibilities, or the specific activities to be performed, as distinguished from the physical requirements for performing those activities. Otherwise, the employee cannot know whether the work is something he or she is willing to do, as distinguished from what he or she is capable of doing.

The Court stated in this case, the employer's job offer arguably provided information sufficient to show that the offered job met two of the minimum statutory requirements. The information indicated the physical requirements of the offered job were consistent with the work restrictions

imposed by Dr. Peterson. By providing the address where the job was to be performed, the job was within reasonable commuting distance from applicant's residence at the time of injury.

However, the Court went on to say that the information provided by the employer was insufficient to show that it was a regular position or one lasting at least 12 months. It provided no information about the compensation. Finally, the vague and possibly contradictory descriptions of the position as guest-services cashier and general production were insufficient to apprise the Applicant of the job responsibilities. The employer argues that the Applicant had the burden to contact the supervisor named in the offer and inquire into the minute details of the job responsibilities, compensation and duration of employment. The Court indicated they rejected this argument. Subdivision (a)(5) and (6) of L. C. §4644 essentially establishe the minimum requirement for modified or alternative work that may effectively be substituted for rehab services. As such, these requirements extend to injured employees as a measure of protection in a statutory procedure otherwise designed to limit their vocational rehab benefits. The burden is on the employer to include in its offer information sufficient to show the job being offered satisfies the minimum requirements of subdivisions (a), (5) and (6).

The Court then turned to the employer's contention that the matter should be remanded for further development of the record. The Court indicated this argument was not persuasive. The employer did not specify the issues requiring further development of the record, but simply cited the opinion expressed by the Board's dissenting commissioner. The dissent favored remand only to resolve a conflict between the employer's offer which stated the job's physical requirements were within Applicant's work restrictions, and Applicant's offer of proof, which attested that the employer could not feasibly offer a job within these restrictions. If for the sake of argument the Court resolves this conflict in the employer's favor, the offer remains ineffective nevertheless. The information included in the offer did not show that the offered job was a regular position and did not mention anything about compensation, duration of employment, and job's responsibilities.

In the opinion of the Court, it would serve no purpose to develop the record further on the issue of the job's physical requirements.

Finally, the employer argued that the Board's decision should be annulled as procedurally defective because the WCJ was unavailable to prepare a report and recommendation on petition for reconsideration. The Court found no merit in this argument. The WCJ's report was required pursuant to Rule §10860 adopted by the Board to regulate its own proceedings. The Board acted within its powers to waive the rule and proceed without the report. The Board's decision satisfied the requirements of L. C. §5908.5 that the decision state the evidence relied on and specify in detail the reasons for its decision.

2. Jimenez v. San Joaquin Valley Labor (2002) 67 CCC 74 (Board En Banc).

Applicant sustained an injury on August 24, 1994 while employed as a seasonal farm worker. Her job consisted of picking grapes, packing the grapes into crates, and stacking the crates on pallets. The grape picking season was from August 16, 1994 through October 25, 1994. The parties stipulated that applicant's earnings in-season were $405 per week and $0 per week in the off-season.

Applicant was paid temporary disability indemnity and VRMA at various rates and for various periods; but initially defendant paid temporary disability at $269.50 per week, including during off-season periods. Beginning on March 3, 1995 defendant began paying temporary disability at $10.00 per week because "the season ended in October."

Applicant was a qualified injured worker and participated in vocational rehabilitation between April 16, 1996 through October 25, 1996 and from April 2, 1997 through August 22, 1997. Rehabilitation services did not result in new employment.

At trial, the WCJ found that applicant's in-season temporary disability rate was $270.00 per week and that her off-season rate was $0 per week. However, the WCJ found that her VRMA rate was $246.00 per week irrespective of whether she participated in-season or off-season.

Defendant filed a petition for reconsideration. It claimed a credit for overpayment of temporary disability, disputed the permanent disability award, and contested the award of VRMA at $246.00 for all periods of her participation. The Board accepted reconsideration, en banc, but addressed only the VRMA rate issue.

In considering the issues presented, the Board first reviewed the law relating to temporary disability indemnity for seasonal employees. It noted that the "average weekly earnings" for temporary disability might be different for temporary disability purposes than for permanent disability. Ordinarily, the average weekly earnings of a seasonal employee are computed under Labor Code §4453(c)(4) and are based upon the average weekly earning capacity.

The Board turned to the case of Grossmont Hospital v. WCAB (Kyllonen) (1997) 62 CCC 1649, to see whether that case required a different approach. In that case, the Board found that there could be only one temporary disability rate. The Board indicated that in Kyllonen, it involved setting the temporary disability rate for a full-time employee who had not been injured would have received regularly scheduled wage increases during the period of TD. Thus the court, in Kyllonen, was not faced with nor, did it address the effect of L. C. §4453 (d) on determining the earning capacity (and temporary disability rate or rates) of workers in seasonal employments who, but for their injuries, likely would have had different earnings, respectively, during the in-season and off-season periods of their temporary disability.

The essential holding of Kyllonen is that an injured employee's temporary disability payment should be based on reasonably anticipated increases or decreases in earnings the employee would have had during the duration of his or her temporary disability, absent the industrial injury.

As stated in *Argonaut Ins. Co. v. Industrial Acc. Com (Montana)* (1962) 27 CCC 130: "…. An estimate of earning capacity is a prediction of what an employee's earnings would have been had he not been injured…. In making an award for temporary disability the [Board] will ordinarily be concerned with whether an applicant would have continued working at a given wage for the duration of disability…"

The Board upheld the WCJ's award of temporary disability based upon the facts of this case, and upon its agreement that the finding of two different temporary disability indemnity rates is fully consistent with the law.

The WCJ determined that an award of VRMA is different, primarily on policy considerations. He reasoned that the Legislature did not intend to carve out a subclass of seasonal workers who might be entitled to rehabilitation benefits, but penalize them in the off season by reducing their rates. This would defeat the purpose of rehabilitation as a matter of public policy.

The Board was sympathetic with the WCJ's position, but held that the Labor Code did not support it. Labor Code §139.5(d) provides that the amount of VRMA due to an injured employee shall be the amount he or she would have received as continuing temporary disability indemnity except the amount shall not exceed $246 per week. Thus, if a seasonal employee's off-season temporary disability indemnity rate is $0 per week, then he or she must receive VRMA at $0 per week during the off-season.

Notwithstanding its discussion of the law, the Board did not believe it was appropriate to make a determination that applicant's VRMA rate in this case was $0 per week in the off-season. It did not feel that it was within the contemplation of the parties when they entered into the stipulation of applicant's off-season earning rate. The Board remanded the case for further determination of applicant's earning capacity, taking into consideration her age, health, skill, training, education, and willingness to work.

3. Jimenez v. San Joaquin Valley Labor (2002) 67 CCC 74 (Board En Banc).

Applicant was injured in the course of her employment. The employer did not make a formal offer of modified or alternative work, but the applicant returned to work and continued to perform modified work. The applicant stopped modified work when her physical complaints forced her to stop working. The applicant was injured on September 15, 1997, and stopped the modified work on September 1, 1999. On February 15, 2000, the parties stipulated that vocational rehabilitation was unnecessary because the applicant was working. Subsequently, however, applicant requested vocational rehabilitation services and the Rehabilitation Unit held a formal conference. At the formal conference on September 27, 2000, it was discovered that the applicant was an undocumented worker.

On October 17, 2000, the Rehabilitation Unit determined that applicant was entitled to vocational rehabilitation services as a result of the 1997 injury. Defendant appealed. After a hearing, the WCJ filed an order denying the appeal and ruling that applicant was entitled to vocational rehabilitation maintenance allowance commencing July 28, 2000.

Defendant petitioned for reconsideration contending that applicant's undocumented status precluded further work for the employer and any right to vocational rehabilitation services, that the applicant's working for over 12 months at modified work constituted a waiver of the employer's obligation to make a formal offer of modified work, and that applicant declined vocational rehabilitation when she stipulated to an award in February 2000.

The panel indicated that the case of *Del Taco v. WCAB (Gutierrez)*, (2000) 65 CCC 342, did not support petitioner's argument that applicant's undocumented status precluded further work for the employee and right to vocational rehabilitation services. In that case the decision was that the employer's obligation to provide vocational rehabilitation services is discharged if the injured employee is unable to accept an offer of modified or alternative work solely because of his or her illegal immigration status.

In this case, however, the employer never made an offer of alternative or modified work as required by Labor Code § 4644(a)(5). That section provides that the employer's liability for vocational rehabilitation services terminated if the employer offers and the employee accepts or rejects, in the form and manner prescribed by the administrative director, modified work lasting 12 months.

The manner of making offers of modified work is prescribed by the Administrative Director in AD Rule §10126(b)(1) which provides that offers to provide alternative or modified employment with the employer shall be made on DWC form RU-94. The injured employee shall accept or reject a bona fide offer within 30 calendar days of receipt of the offer. In the event that the offer is not accepted or rejected within 30 days, the offer is deemed rejected, unless the period of time for reply is extended by the employer or by the terms and conditions of a collective bargaining agreement. The claims administrator shall submit a copy of the acceptance or rejection of the employment offer to the Rehabilitation Unit within 30 days of the acceptance or rejection. In this case, the defendant did not make an offer of bona fide work to applicant in this manner. In the absence of an offer pursuant to the requirements of Labor Code § 4644(a)(5) and AD Rule §10126(b)(1), defendant did meet its obligation and its liability was not terminated by applicant's working at the allegedly modified work for over 12 months.

The Board also rejected defendant's argument that applicant's working for over 12 months at modified work constituted a waiver of the obligation to make a formal offer of modified work. The defendant had cited the case of *Bautista v. W.C.A.B.*, (1998) 63 C.C.C. 1060 (writ denied), to support their argument of waiver. The Board concluded that the present case was distinguishable from the *Bautista* case. In *Bautista* the notice was sent, but late. In this case the panel concluded the notice was never sent.

As to the defendant's last argument, the Board summarily disposed of this by indicating that the applicant did not stipulate that she was not entitled to vocational rehabilitation services, but merely stated that VR was unnecessary at

the time because she continued to work. The circumstances then changed. The panel denied reconsideration.

The Court of Appeal reversed, holding that while theapplicant in this case had not been offered modified work by a RU-104 form, the form is irrelevant when it is undisputed [that] modified work is available but cannot be legally offered and accepted due to the worker's undocumented status. To additionally require the RU-94 to show this on penalty of awarding additional vocational rehabilitation benefits violates the employer's right to equal protection. (Del Taco, supra 79 Ca. App. 4th, at pp 1441-1443.)

In this case there is no dispute that modified work was available to Pinzon. It is unnecessary to re-establish this further by an RU-94, or to require an offer of illegal employment.

4. *Martino v. WCAB (2002) 67 CCC 1273 (certified for publication).*

The applicant was injured in 1995 and thereafter received vocational rehabilitation services, including VRMA. VR services were interrupted, but not closed in 1996, in 1997 and in 1998. In February 1998, the applicant received a PD award of 59 ½%. In 1998, he filed a Petition to Reopen for new and further disability, including a request to reopen VR.

At a formal rehab conference, in May 1998, the Rehab Unit formally closed VR. It was noted that reopening of VR must take place before April 10, 2000, which is five years from the date of injury. In May 2000 the Petition to Reopen was granted and the PD award increased.

In January 2001, within one year of the last finding of PD, the applicant requested reinstatement of VR, which the Rehab Unit held was barred by the five-year statute of limitations. The Rehab Unit consultant noted that the April 1998 Petition to Reopen VR was chronologically out of sequence because at the time it was filed, VR was still open and therefore it did not toll the five year statute. The RU determination was appealed to the WCAB who agreed with the decision of the RU. The applicant sought reconsideration, which was denied. The Court of Appeal granted review.

In a two-to-one decision, the Court of Appeal annulled the Board panel decision. The majority opinion noted that to invoke continuing jurisdiction under L.C. §5410, an appropriate petition must be filed within five years of the date of injury. A timely petition extends the Board's power to reopen and to decide an issue beyond the five-year period.

The Court said the finding of untimeliness is not supported by the facts or the law. The petition to reopen was filed with the WCAB, not with the RU. The only issue before the RU was whether to grant the defendant's April 9, 1998 Petition to Terminate Liability for VR. The RU's decision to terminate VR had no effect on the Board's continuing jurisdiction to act on the Petition to Reopen. A timely petition to reopen remains pending and is not effected by the statute of limitations where there has been no decision by the Board on the specific form of benefits at issue.

Further, neither the statutes nor case law require an injured worker to adhere to a strict chronological sequence when filing documents in an administrative proceedings. The Court said that the Workers' Compensation act disfavors application of formalistic rules of procedure that would defeat an employee's entitlement to VR benefits. The Court gave examples such as *Vasquez v. WCAB* (1991) 56 CCC21 whereby simply checking a box on the application put VR in dispute and tolled the statute of limitations on VR. The dissent said that by filing such a "stealth" petition and then doing nothing about it before the RU and allowing VR to be closed, the worker can later claim the closure had no effect. This is like filing a motion for a new trial before the verdict has been rendered.

The order denying the applicant's petition for reconsideration was vacated, and the matter remanded for a new order granting the petition.

XIV Permanent Disability

Alistar Insurance Co. v. W.C.A.B. (Whitaker) (2002) (writ denied) 67 CCC 161.

Applicant claimed injuries to multiple body parts; defendant admitted injury to applicant's right knee. Applicant received treatment, and after objection and attempt to agree to an AME, defendant obtained a QME evaluation. At an MSC the parties were directed to list proposed PPD ratings. Defendant proposed 40%; applicant proposed 64%. After trial, the WCJ issued formal rating instructions, and a rating of 75% issued. After cross-examination of the rater, the WCJ issued Findings and Award for 75% permanent partial disability. Defendant contended on reconsideration that the WCJ was limited to one or the other of the 40% or 64% proposed ratings.

The WCJ reported that Labor Code 4065 was not controlling because the injury involved disputed body parts. The Board noted that the proposed ratings did not include the disability numbers for each body part where there was permanent disability. The Board denied reconsideration, and defendant's petition for writ of review was denied.

XV Apportionment

1. *Serrano v. State Compensation Insurance Fund*, (2002) (Board Panel Decision) 30 CWCR 165.

Applicant injured his spine, arms and right leg in the course of his employment on November 6, 1985. He had previously injured the same parts of his body in 1970. A hearing was held on the claims on December 3, 1991. At that hearing State Fund admitted the injuries. The parties agreed on medical evaluations by a psychiatrist, an internist and an orthopedic surgeon. The case was ordered off calendar. Applicant was subsequently examined by the three AMEs. AME John Suarez, M.D. was chosen in psychiatry. In his report, Dr. Suarez discussed apportionment. He indicated that the issue of apportionment in the case was at best tricky. He considered the depression to have multiple contributions. The bulk of it derived from the chronic orthopedic problems. He deferred to the orthopedist as to the breakdown between the first accident in 1970 and the one now under litigation from 1985. He ascribed the rest of the depression to issues in the applicant's personal life. Work restrictions and need for vocational rehabilitation were strictly in an orthopedic realm. He recommended prompt resolution of the litigation.

The matter then came up for further hearing on June 21, 1999, and the AME reports were received in evidence on the issues of permanent disability and apportionment, among others, and the matter was submitted on the record. Pursuant to the WCJ's instructions, a Disability Evaluation Specialist prepared a formal rating determination, recommending 74-3/4 percent PD. On cross-examination by defendant, the Disability Evaluation Specialist suggested that Dr. Suarez's report needed clarification. The defendant then moved that the WCJ vacate submission and order applicant to be evaluated by an independent medical examiner, because Dr. Suarez was no longer available for a supplemental report. The WCJ issued that order. Applicant petitioned for an order from the Board removing the case to itself and setting aside the order vacating the submission. The applicant contended that the defendant had the burden of proof on apportionment and any lack of evidence on the issue was defendant's own fault. Defendant neither objected to nor sought clarification of Dr. Suarez's opinion when it was rendered in 1994.

The panel concluded on reconsideration that applicant's argument had merit. The Court indicated that developing the record on PD was not warranted. No one disputed that the factors of psychiatric disability described by Dr. Suarez called for a standard PD rating of 60 percent. It was also clear that Dr. Suarez attributed 80 percent of the disability to orthopedic injuries. Although the doctor did not indicate the amount attributable to the 1970 injury, a 1973 report from Jerome H. Franklin, M.D., an expert in psychiatry, said that applicant was not then seriously depressed or in need of psychiatric treatment for depression. The panel reviewed the law on the evidence required to justify a portion of PD. L.C. §§4463 and 4750 make provision for apportioning PD. Apportionment under L.C. § 4750 requires a showing that there was a preexisting ratable disability at the time of the injury. Medical opinion must establish pre-existing disability and describe its exact nature and the expert's rationale. Pre-existing disability may not be based on conjecture or retroactive prophylactic work restrictions. To justify apportionment under L.C. § 4663, the medical evidence must establish the injured worker would have been disabled as a result of the normal progress of a non-industrial condition in the absence of the industrial injury. Evidence that the disease would have caused disability at an indefinite future date is not sufficient to support apportionment. A showing must be

made that it would have occurred by the time the disability from the injury became permanent and stationary.

Under both statutes, the employer is liable to the extent that an injury accelerates, aggravates or lights up the pre-existing condition. Neither section permits apportionment to causation. It is the defendant's burden to prove apportionment.

Based on these principles, the panel said that although there might be some apportionment to applicant's long-standing psychiatric problems, evidence justifying apportionment to the 1970 injury was lacking. Dr. Franklin's 1973 report indicated no ratable depression from that injury.

The panel found it particularly distressing that the defendant did nothing to clarify the report of Dr. Suarez until the June 21, 1999, trial, almost five years after the report period. The Board pointed out that apportionment is defendant's burden of proof. If defendant had questions as to the meaning of any portion of Dr. Suarez's opinion, defendant could have cross-examined him. Defendant's failure to do so does not justify obtaining a report from another psychiatric expert. The Board went on to further state that they are persuaded that the record contains sufficient evidence on all issues and needs no further development. The Board removed the case to itself and issued an order vacating submission and returned the case to the WCJ for a decision consistent with its opinion.

2. *Yellow Freight Systems, Inc. v. W.C.A.B. (Chavira)* (2002) (writ denied) 67 CCC 209.

Apportionment (Labor Code §4750); medical rehabilitation. Applicant sustained an injury in 1988 to his neck, back, and psyche. The case was resolved in 1992 by stipulations for 15:2% permanent partial disability, of which the orthopedic component was 14%. He was precluded from heavy lifting and was medically eligible for vocational rehabilitation. Following that injury, applicant returned to work as a dock worker. Deposition testimony was that he worked as a dock worker. While he had back symptoms, these did not require medical treatment through 1997. In his current cases, for back injuries of 8/31/97 thru 8/31/98 and on 8/31/98, the AME indicated that applicant now had disability over and above that awarded in 1992. The WCJ found that defendant had met the burden of proof of apportionment, and awarded 21% permanent disability after apportioning out 14%. Applicant sought reconsideration. The WCJ recommended reconsideration be denied. The Board granted reconsideration and held that where applicant had returned to heavy work, had disregarded the prophylactic restriction recommended in 1992, and had worked without evidence of interference by his prior disability, it could not be found that applicant was suffering from a preexisting ratable disability at the time of his 1998 injuries. The Board concluded that applicant was entitled to an award of 35% without apportionment. Defendant's petition for writ of review was denied.

XVI Death Benefits

Smith (Stephen J.) v. W.C.A.B. (Walker) (2002) 67 CCC 121.

An employee who sustained fatal injury had paid his parents $150 per month "rent." The WCJ and WCAB found the parents were partial dependents and awarded $7,200 in dependency benefits. The Court of Appeal reversed, holding that the value of the room and board received should be deducted from the employee's contributions to the household, and where the room and board value exceeded the rent, there was no dependency. The matter was remanded with direction to enter an award in favor of the Death Without Dependents Unit.

XVII Hearings, Discovery Closure, WCJ's development of the record.

1. *Andrade v. California Insurance Guaranty Association,* (2002) (Board Panel Decision) 30CWCR 132.

Applicant was employed as a farm laborer from 1991 to May 11, 1998 when he suffered a ruptured berry aneurysm with subarachnoidal hemorrhage while repairing a piece of farm equipment. The applicant mailed a claim form alleging a cumulative trauma that was received by the employer on February 1, 1999. The claim form was forwarded to California Compensation Insurance Company, the employer's insurer. The insured denied the claim on May 11, 1999. Applicant's QME found the injury compensable, and the defense QME found that the aneurysm was not work related. The parties executed a Compromise & Release which was submitted to the WCAB for approval. The C&R recited that applicant was claiming both a cumulative and a specific injury on May 11, 1998. The WCJ had reservations about the adequacy of the settlement and set it for a mandatory settlement conference. At the MSC the defendant listed four witnesses. The matter came to hearing on June 21, 2001. Defendant offered the testimony of one witness, the employer, by deposition. Applicant offered the deposition of the spouse and the treating physician. The treating physician testified in his deposition that the fact the aneurysm ruptured during or right after heavy work made the work a likely contributing factor. The depositions and medical reports were received in evidence. The parties submitted on the record as outlined above.

On September 5, 2001, the WCJ found that (1) applicant had sustained both a cumulative and specific injury; (2) the injuries caused temporary disability and permanent total disability; (3) the injuries were presumed compensable pursuant to L. C. § 5402, and (4) the C&R was inadequate.

CIGA, which had stepped in when Cal Comp became insolvent, petitioned for reconsideration, contending the presumption was inapplicable, the findings of injury were not justified by the medical evidence, and the WCJ should have developed the record on the issue of whether applicant's activity on May 11, 1998 was sufficient to cause the aneurysm to rupture.

Reconsideration was granted for further study. The WCAB panel first concluded that there was no basis to develop the record further. The Board concluded that the filing of the C&R constituted the filing of an application, thereby representing that discovery was complete and the record sufficient, not only for evaluation of adequacy, but also for decision on the merits. Defendants were put on notice of the specific injury claim from

the report of their own QME, who discussed it. Applicant's QME report also indicated there was a specific injury. Defendants and applicant agreed to a settlement of the specific injury claim in the Compromise & Release. The Board further stated that the fact the WCJ did not hear testimony from defense witnesses who had been present when applicant collapsed, was defendant's fault. When discovery closed at the MSC, petitioner listed four witnesses, but produced only one at the formal hearing. In addition, the petition for reconsideration was silent as to the names of the witnesses that could shed more light on applicant's activities or as to what the witnesses would say. In the opinion of the Board, defendants had ample opportunity to have discovery, identify, and produce eye witnesses but failed to do so. The Board pointed out that any residual doubt as to applicant's precise activities was of defendant's own making. The Board concluded there was no basis for further development of the record.

The Board, turning to the presumption of L. C. § 5402, concluded that the cumulative injury, but not the specific injury, was presumed compensable. The claim for the cumulative injury was not denied by Cal Comp until 99 days after the claim form was received by the employer and therefore was presumed compensable. The Board stated that there was nothing in the letter of transmittal or in the claim form that put the defendant on notice that they were reasonably certain that a specific injury occurred or was being claimed.

The Board went on to state that even if neither injury was presumed compensable, the medical evidence justified the WCJ's finding of a specific injury on May 11, 1998. Both doctors had the same history. In the opinion of the Board, Dr. O'Brien's apparent conclusion, that there was no straining in using a hammer and wrench to loosen bolts, seemed to reflect an arbitrary value judgment that was not supported by the record. The applicant's QME's opinion that the physical exertion on May 11, 1998 contributed to the rupture of the aneurysm, buttressed by the treating physician's deposition, was substantial evidence as to the fact that the specific injury that arose out of and occurred in the course of employment.

The decision of the WCJ was affirmed.

2. *City of Taft v. WCAB (Kizzar),* (2002) (not published) 67 CCC 524.

The applicant, while employed as a police officer, was injured in December, 1997, in a motor vehicle accident. Another vehicle ran a stop sign and pulled out in front of him. The applicant filed both a Workers' Compensation claim and a third party lawsuit against the other driver. The applicant recovered policy limits of $100,000 in the third party case. The employer filed a lien in excess of $45,000, seeking credit for compensation benefits paid. The applicant raised the issue of employer negligence, claiming that the City failed to adequately maintain the brakes on his police car. The matter was tried before an arbitrator who found that the applicant's total economic and non-economic damages were more than $293,000 and that the City was 35% negligent. The city is, therefore, not entitled to a credit against the applicant's net recovery until it has spent $102,000 in compensation benefits.

The City filed for reconsideration, arguing that the applicant failed to meet his burden of proof that the City's breach of duty was the proximate cause of his injuries, and that the 35% negligence finding was excessive.

In his report on reconsideration the arbitrator acknowledged that no expert testified with respect to the brakes on the police car, but he took judicial notice that anti-lock brakes reduce stopping distance and enhance controllability. By inference, proper operation of the brakes could have prevented the accident or made it less severe. The Board panel adopted the arbitrator's opinion.

The DCA panel noted that under Evidence Code §669, failure to exercise due care is presumed if a statute is violated. Vehicle Code §26453 provides that brakes must be maintained in good working order, so failure to do so gives rise to the presumption. To apply, the violation must be a proximate cause of the injury. The Court took notice of the applicant's testimony that the brakes failed to operate properly causing his car to skid.

The Court criticized the arbitrator for taking judicial notice with respect to anti-lock brakes as these are matters not universally known or easily ascertainable, citing Evidence Code §452. The Court went on to say that this was not reversable error, because the applicant testified about how he was trained as to the proper use of brakes and that if the brakes would have functioned properly he would have been able to avoid the accident. The testimony alone was sufficient to establish the brake failure as a proximate cause of the injuries.

3. *McDuffy v. Los Angeles County MTA* (2002) (WCAB En Banc) 67 CCC 138.

Directions for augmenting the record where further medical evidence is required. "The preferred procedure is first to seek supplemental opinions from the physicians who have already reported in the case." If supplemental reports or depositions of those physicians "cannot or do not sufficiently develop the record" the parties should be encouraged to select an agreed medical examiner (AME). Only if the preceding measures fail may the WCJ appoint a medical examiner.

4. *Tillie v. Citrus Community College District* (2002) (Board Panel Decision)
30 CWCR 126.

The applicant filed an application for adjudication of his claim, alleging that he sustained a psychiatric injury as a result of unfair discriminatory treatment by his supervisor, E. Van Banks, from 1995 through 2001. Three days after the application was filed, the attorney for the applicant served on the employer a demand for production of the personnel file of E. Van Banks, including, but not limited to, his application for employment, correspondence of hiring, firing, or termination for any reason, evaluations, change in position or title, and medical records. Defendant refused to comply and the applicant filed a Declaration of Readiness to proceed. After a hearing, the WCJ ordered

defendant to produce the records, and defendant filed a Petition to Remove with the Appeals Board.

The panel noted that because the discovery order was not a final order subject to reconsideration, removal was the appropriate remedy. The Board pointed out, however, that removal is ordered only if there is a showing that substantial prejudice or irreparable harm will result if relief is not granted. The Board indicated that Van Banks would have suffered substantial prejudice and irreparable harm if the employer released privileged information or abated his right to privacy.

Turning to the question of whether the requested discovery was permissible, the panel explained that discovery is permissible only if the information sought is relevant to the proceeding or reasonably calculated to lead to the discovery of admissible evidence that is not privileged. Discovery that violates a person's right to privacy may not be permissible. That right is granted by the California Constitution, which provides protection from disclosure by private, as well as, governmental entities. An invasion of this right must be justified by substantial countervailing interests and the lack of an effective alternative with a lower impact on privacy. The panel added that Civil Code §§56 through 56.37, the Confidentiality of Medical Information Act, expressly extends the right of privacy to medical information. § 56.20(c) of that act provides that no provider shall disclose medical information pertaining to its employees without authorization from the patient, except when compelled by judicial or administrative process or by specific provision of law. Information relevant in a lawsuit or other claim to which the employer and employee are parties may be disclosed if the patient had placed in issue his or her medical history, mental or physical condition or treatment. Information may be used for administering workers' compensation benefits. Read in light of the *Hill v. National Collegiate Athletic Association,* (1994) 7 Cal 4th 1, this section mandated that medical records pertaining to Van Banks in defendant's possession were entitled to the right of privacy and are not discoverable by applicant. No sufficient countervailing interest that outweighed his right to privacy appeared. He was neither a party to the case nor had he placed his medical condition in issue. Applicant has not established any nexus between Van Banks' medical condition and his alleged harassment of the applicant.

Rejecting applicant's assertion that medical information about Van Banks would be relevant to a possible claim that the alleged injury was caused by the employer's serious and willful misconduct, the panel said that it could not see the relevance. In any event, there was no S & W claim on file. Applicant was free to depose Van Banks on all matters relevant to the alleged injury, but Van Banks' medical information was privileged.

The panel concluded that if the WCJ's discovery order were allowed to stand, defendant would be unable to ensure the confidentiality of medical records owed to Van Banks. Applicant could still subpoena portions of Van Banks' personnel file, but would have to narrow the demand to documents relative to the claim, such as complaints about Mr. Van Banks and dispositions of those complaints, if any. Accordingly, the panel removed the case to itself, rescinded the order and returned the case to the trial level.

XVIII Compromise and Release

1. Hall v. Valley Media (2002) (WCAB Significant Panel Decision) 67 CCC 1147.

Applicant suffered injury AOE-COE to his back on May 8, 2000. Applicant and Legion Insurance executed a Compromise and Release settling applicant's claim for $35,000.00 on November 13, 2001. The settlement was filed for approval on February 5, 2002. On February 25, 2002, the WCJ advised defendant that filing of notice of applicant's entitlement to a QME evaluation would be required before settlement approval. No response was received, and the matter was set for hearing on May 1, 2002. On March 28, 2002, the State of Pennsylvania placed Legion Insurance Company into rehabilitation, and requested a ninety day stay in proceedings against Legion. At the May 1, 2002, hearing, the requested benefit notice was produced, applicant indicated he wished to proceed with the settlement, but defendant requested to withdraw from the settlement.

The WCJ approved the Compromise and Release, and specified in the Order Approving Compromise and Release that payment was to be made within twenty-five days or penalties and interest would be added. Defendant sought reconsideration contending it should have been allowed to withdraw from the settlement because of the imposition of rehabilitation. The WCJ, in her report and recommendation, noted that WCAB Chairman, Merle Rabine, had issued a memorandum indicating that the stay provision of the Pennsylvania court was not binding on proceedings before the Appeals Board in California; that good cause had not been shown to allow Legion to withdraw from the Compromise and Release agreement; that there was no showing of Legion or the rehabilitator's inability to pay the settlement, and that paragraph 10 of the Compromise and Release implicitly provided for payment within 25 days.

The Board noted that no mutual mistake of fact had been demonstrated, nor had inability of the rehabilitator to pay the settlement been shown. The Board did receive a memorandum from the rehabilitator indicating that lump sum awards would be paid by periodic payments, but found no basis, rationale, or justification for the instruction. Absent a showing of good cause as to why a lump sum payment may not be made in a particular case, payment of a lump sum would be expected and required. The Board noted that settlements could be fashioned to provide for periodic, as opposed to lump sum payment, of settlement proceeds.

The Board then turned to the impact of the ninety day stay on proceedings for collection of California workers' compensation benefits. It held that the stay request standing alone does not illustrate good cause for delaying proceedings. Some further explanation or justification, showing how such delay would preserve or stabilize defendant's assets, would be required. The Board noted that Pennsylvania has the ability to apply to California Courts for injunctive relief, if necessary, to preserve assets and neither the rehabilitator nor any other party had applied for such relief on behalf of Legion.

Finally, the Board turned to the provision in the Order Approving Compromise and Release expressly providing that penalties and interest would be imposed if payment were not made within twenty-five days. The Board held that such provision impermissibly rewrote the terms of the settlement and deprived the defendant of an

opportunity to be heard as to the reasonableness of delay. The Board held that provision violated the prohibition against rewriting the parties' agreement found in *Burbank Studios v. Workers' Compensation Appeals Board (Yount)* (1982) 47 CCC 399, deprived defendant of due process rights and was ordered stricken.

2. *Jefferson v. State of California, Department of Youth Authority,* (2002) (Califonria Supreme Court) 67 CCC 727.

The plaintiff was employed by the Youth Authority as a teacher's assistant from September 1992 to February 1994. During that time, the teacher and his students allegedly used derogatory language when referring to females, such as "bitch," "whore," and "slut." The plaintiff was offended, so she complained to the teacher and his supervisors, but the conduct continued. As a result of her complaints, in February 1994, she was told not to return to that teacher's classroom. Two days later her doctor took her off work, due to job-related stress. Two days following that she received a memo reassigning her to a different classroom, but she never returned to work.

In March 1994 the plaintiff filed a workers' compensation claim alleging injury to her psyche, hypertension, and allergies. In her report to the employer, she claimed her injuries were due to sexual harassment from the teacher and his students.

In October 1994 the plaintiff filed a FEHA sex discrimination claim with the Department of Fair Employment and Housing. She alleged in the claim that she was subjected to sex harassment in the work environment. In October 1995, the Department of Fair Employment and Housing sent her a right-to-sue letter.

In July 1996 she settled her workers' compensation claim and signed a compromise and release. She read the release before signing it, and she was represented by counsel at the time. The release included language that the plaintiff forever discharged the employer from all claims and causes of action, whether now known or ascertained, or which may hereafter arise or develop as a result of said injury. The settlement stated: "Applicant agrees that this release will apply to all unknown and unanticipated injuries and damages resulting from such accident, and all rights under §1542 of the Civil Code of California are hereby expressly waived."

The applicant resigned her employment with the Youth Authority in June 1996, because she believed the employer would not settle with her unless she did so. In August 1996 the Compromise and Release was approved. The plaintiff filed her civil lawsuit against the Youth Authority three weeks later. The defendant then filed a motion for summary judgment as to the FEHA action.

The trial court granted the motion on the ground that the Compromise and Release barred her complaint as a matter of law, even though the release was clearly outside the scope of workers' compensation. Having accepted the $49,500 settlement amount, the court found the plaintiff could not avoid the express terms of the release. The plaintiff appealed.

Generally, a written release extinguishes any obligation covered by its terms, provided it has not been obtained by fraud, deception, misrepresentation, duress, or undue influence.

When a person capable of reading and understanding a release signs it, then he or she is bound by its provisions and is estopped from claiming they are contrary to his or her understanding or intentions. Assent to a release agreement is necessary for the release to be binding. Here, the plaintiff claims she never intended to abandon her FEHA discrimination claim. The DCA it would enforce the outward expression of the agreement, rather than a party's unexpressed intentions. Even though the plaintiff intended to release only the workers' compensation claim, she did not say so in the release. There was no evidence that any party discussed whether the release would encompass the FEHA claim or not. The release also released co-employees, which indicates the release was intended to encompass civil claims as well.

The DCA overruled the holding in *Delaney v. Superior Fast Freight,* (1993) 14 Cal.App.4th 590. The DCA held the only difference between *Delaney* and the case at bar is that the release in *Delaney* did not include a clause also releasing co-workers from liability. The Court said they specifically disagree with the holding in *Delaney* regarding whether a workers' compensation release encompasses a civil claim, stating that *Delaney* lacks any authority to support the conclusions made. *Delaney* is not well-founded in either case law or statutory authority. Instead, the case law says that when the releasor is aware of a claim that he does not intend to release, he has a duty to so specify in the written release.

The DCA declined to rewrite the appellant's release agreement to include a concept she failed to enunciate at the time she accepted the terms of the agreement with the employer. The DCA found the release to be complete, explicit, and as unambiguous as a general release can be. The DCA said it is a beneficial principle of contract law that general releases can be constructed so as to be completely enforceable.

The DCA said the fact that the settlement was brought in the workers' compensation forum does not render the general release inapplicable to claims in other forums. To conclude otherwise would result in the erosion of the effectiveness, reliability, and predictability of a general release. Parties would be deprived of the peace of mind such a release is intended to bring. The DCA said that if a releasor is aware of other claims in other forums, the burden is on them to specify in the release the nonrelinquishment of such claims.

The DCA reiterated that plaintiff's claim was barred by the general release, and the judgment of the Superior Court was affirmed. The plaintiff then sought review before the Supreme Court.

The Supreme Court upheld the DCA opinion saying that when an employee has knowledge of a potential claim against the employer at the time of executing a general release in a workers' compensation proceeding, but has not yet initiated litigation of that claim, the employee has the burden of expressly excepting the claim from the release. Absent this exception, and absent contrary extrinsic evidence, a court will enforce general language, such as is found in the Compromise and Release and attachment in this case, releasing all claims, including civil claims. The Supreme Court held that the broad language in the Compromise and Release covers the FEHA action. The judgment of the Court of Appeal was affirmed.

XIX Findings and Awards and Orders

XX Reconsideration

Marriott International v. WCAB (Gomez), (2002) (not published) 67 CCC 713.

After an expedited hearing on May 9, 2001 the WCJ dictated the minutes of hearing, summary of evidence, and his decision, all in the same document. Although the record indicated that all parties were served on May 14, 2001, defendant did not receive it. On July 16, 2001 the defense counsel contacted the applicant's attorney and was advised that a decision had issued and was faxed a copy. On July 18, 2001 the applicant's attorney mailed a copy to the defendant. The defendant filed a Petition for Reconsideration on August 8, 2001 which is 23 days after the fax and 21 days after receipt of the mailed copy. The Board panel dismissed the Petition as being untimely because the Board considered the fax transmittal to be "in effect personal service" rather than mail service so the defendant would not be entitled to the 5 days for mailing pursuant to CCP § 1013.

The defendant filed for review, arguing that service by fax is permitted under CCP § 1013 upon agreement of the parties, and here the defendant did not agree. Since the fax service was defective, it could not be used to start the time limit for purposes of filing the Petition for Reconsideration. Therefore, the 5 additional days for mailing would apply, and the Petition was timely.

The DCA found the Board conceded error, acknowledging that the fax service was not authorized under CCP § 1013, and, therefore, it did not constitute personal service. The matter was removed back to the Board to decide the case on the merits.

XXI Judicial Review

City of Lindsay v. W.C.A.B. (Martinez) (2002) (not published) 67 CCC 1.

Applicant was a police officer for the City of Lindsay during the period from December 13, 1992 to February 1998. He alleged an industrial injury as a result of continuous trauma to his psyche, bilateral upper extremities, and high blood pressure. Defendant denied the injury.

The WCJ issued a Findings and Award finding injury to applicant's psyche and hypertension. He stated that applicant had been without psychiatric problems before he began working for defendant and that things went well for a time. Applicant was an acting sergeant beginning in 1996, and was promoted to sergeant in 1997. The WCJ further noted that there was evidence of personal problems and alcoholism. Without identifying them, the WCJ held that the predominant cause of injury was stressors of police work as noted by the doctor.

On Reconsideration the WCAB adopted the Report and Recommendation on Petition for Reconsideration of the WCJ without discussion. The Court of Appeal concluded that the

WCAB had not adequately set forth its reasons for denying the Petition for Reconsideration as to applicant's psychiatric injury and remanded the matter to the WCAB for further proceedings.

The issue presented on the psychiatric claim was whether applicant had met the threshold of compensability set forth in Labor Code §§3208.3(b)(1) and 3208.3(h). § 3208.3(b)(1) requires that actual events of employment were predominant as to all causes combined of a psychiatric injury. Section 3208.3(h) bars recovery if the injury was substantially caused by a lawful, non-discriminatory, good faith personnel action.

The Court cited several items discussed by the doctor. They included applicant's success in helping to curb gang activity, alienation because he stopped drinking with his fellow officers after work, being suspended by his supervisor during an investigation, and his resignation in anticipation of further discipline. The Court also noted that applicant had numerous personal problems. His ex-wife was a heroin addict; he had a daughter that was part of a gang; applicant's problem with alcohol; and being arrested for spousal abuse.

L. C. §5908.5 requires the WCAB to state the evidence relied upon and specify in detail the reasons for the decision. The purpose for that requirement is to facilitate meaningful judicial review of Board decisions.

The Court remanded the case because the Board did not identify the "stressors of police work." Nor did it adequately address the contention that the personal stressors were the predominate cause of injury, or that any psychiatric injury was caused by good faith personnel action.

XXII Reopening

Fekkers v W.C.A.B. (2001) (writ denied) 67 CCC 92.

Applicant sustained an injury to her neck and low back AOE/COE on 11/9/91. A Stipulated Award issued on 1/14/91 (sic), in which it was found that applicant's injuries caused PD of 30%.

On 10/25/94, applicant filed a Petition to Reopen based upon the report of Dr. Ju-Sung Wu, which alleged that she was TTD. Applicant was examined by AME Dr. Richard Scheinberg on 1/23/97, and he declared applicant P&S.

On 3/18/98 applicant underwent epidural injections. In a report dated 1/7/99 Dr. Wu declared for the first time that applicant was TTD. The AME later opined that applicant became P&S on 1/23/97, but that applicant would have been considered TTD during the course of subsequent evaluation and treatment.

The Petition to Reopen proceeded to a regular hearing. An Award issued on 7/2/01, finding, inter alia, that applicant was entitled to TD for the period 10/23/96 through 1/23/97 and that applicant was P&S on 1/23/97. The WCJ further found that the WCAB

lacked jurisdiction to award TD for the period commencing on 1/7/99, pursuant to the five year jurisdictional period.

Applicant filed for Reconsideration, contending that the WCAB continued to have jurisdiction because the Petition to Reopen was filed before the running of the jurisdictional time limit.

The WCJ's response indicated that the WCAB retained jurisdiction to amend an award pursuant to Labor Code §5804 more than five years from the date of injury if: (1) the Petition to Reopen was filed before the running of the jurisdictional time; and (2) if the new and further TTD began before the running of the five-year period after the injury. The WCJ cited *Walton v. Hartford Insurance Co.* (1993) 21CWCR 293 (Board Panel Decision)

In denying the period of TTD after 1/7/99, the WCJ cited *Joani Beck (Hambrick) v. WCAB* (2000) 65 CCC 845 (writ denied). That case held that the WCAB lacked jurisdiction under Labor Code §5410 to consider a Petition to Reopen for TTD, even though the Petition had been filed within the five-year period, since the TTD did not start to run until after the running of the jurisdictional time period.

The Board adopted the report of the WCJ. Applicant's Writ was denied.

XXIII Statute of Limitations

1. *Crown Cork & Seal v. W.C.A.B. (Fields)* (2002) (writ denied) 67 CCC 175.

Applicant sustained an injury on May 27, 1987 while employed by Tri Valley Growers. The claim was resolved by Stipulations and Award providing 5:2% permanent partial disability and medical treatment. In June 1994, Tri Valley sold out to Crown Cork & Seal. Applicant completed a DWC Form 1 Claim form on February 20, 1998, and defendant employer's personnel department employee inserted the date of injury "2/2/98". The Claim Form was received by Travelers on February 20, 1998. Travelers issued a denial of claim on May 12, 1998. Fields continued to work and continued to receive medical treatment from Tri Valley Growers. Treatment included surgery on February 23, 1999. Applicant returned to work at Crown Cork & Seal in October 1999, and continued until the plant closed in December 2000.

In February 2000 Tri Valley's QME opined that applicant's increased symptoms, increased permanent disability, and need for surgery were the result of cumulative trauma while working for Crown Cork & Seal through February 1999. On September 8, 2000, Tri Valley filed an Application for Adjudication of Claim alleging Fields had sustained CT injury to his back through 2/2/2000. Crown Cork & Seal and Travelers issued no denial within 90 days of the 2/2/2000 application. Crown Cork & Seal and Travelers contended the CT was barred because more than one year had elapsed from the May 12, 1998 denial of claim to the date of application. The WCJ found that defendant Crown Cork & Seal and Travelers had not provided applicant benefit notices required by A. D. Rule 9882 in 1998, in 2000, or at any time before filing its answer (October 18, 2000). The WCJ opined that not only were Crown Cork & Seal and Travelers estopped from

asserting the statute of limitations, but that the injury was presumptively compensable under Labor Code §5402. The Board denied Crown Cork & Seal and Travelers' Petition for Reconsideration. The Court of Appeal denied Crown Cork & Seal and Travelers' Petition for Writ of Review, but granted applicant's request for attorney's fees.

2. *Kelley v. American Motorists Insurance Company* (2002) (Board Panel Decision) 30 CWCR 163.

Applicant injured her head and neck while employed at Coast Hardware on May 21, 1993. On June 4, defendant, American Motorists Insurance Company, the employer's insurer, sent the applicant a claim form and Notice of Potential Liability for Benefits. The notice said, among other things, you may contact the state's office of Benefit Assistance Enforcement if you need help filling out this form. There is no indication the applicant ever returned the claim form, but defendant accepted the claim, provided medical treatment and paid temporary disability. On March 4, 1994, the defendant notified applicant that it appeared she had fully recovered from the effects of the injury. The notice advised the applicant that she had one year from the date of the last provision of benefits or five years from the date of injury to apply for new and further benefits before the Workers' Compensation Appeals Board. It further indicated that if she had any questions, she could contact the Information and Assistance Officers at the WCAB. The applicant received the notices. An application was filed on December 3, 1999. No benefits were provided in the way of compensation for medical treatment after March 4, 1994.

The applicant consulted an attorney, who declined to take the case because too much time had passed since the specific injury occurred and because she did not need an attorney for a separate cumulative injury claim. The applicant then went to an Information and Assistance Officer and related what the attorney had told her. The Information and Assistance Officer neither agreed nor disagreed with what the attorney said about the specific injury, but apparently assisted her with the cumulative injury claim and application, which was filed on August 18, 1998. The application alleged a cumulative spinal injury culminating on November 23, 1997. The claim was closed by Order Approving Compromise and Release filed December 2, 1999.

At the hearing on adequacy of the C & R, the WCJ and the attorney defending the cumulative injury claim told the applicant she had been misinformed about the specific injury claim and should immediately file an application, which she did the following day. A hearing was then held on the specific injury claim, at which the applicant testified to the facts as stated above. Copies of the notices sent to her by defendant were received in evidence. The WCJ found the claim was not barred by the one-year limitation, L. C. § 5405, or the five-year limitation of L.C. §5410. The WCJ reasoned that because applicant had been misinformed of her rights by the I&A officer, the Doctrine of Equitable Tolling applied. Defendant filed a Petition for Reconsideration.

A panel granted reconsideration, finding merit in defendant's arguments. The panel first noted that the normal limitations period for commencing proceedings for the collection of compensation is one year from the date of injury, the last payment of compensation or the last furnishing of medical treatment. If benefits are provided, L.C. § 5410 extends

the period to five years from the date of injury. The Board stated that applying these principles to the facts before it, the panel said that to have been a timely claim for further benefits, it would have had to have been filed by May 21, 1998. The application, filed on December 3, 1999, was obviously late. The next issue the Board dealt with was whether there was a basis for estoppel. The Board concluded there was no basis for estoppel. Applicant was advised of her right to seek the assistance of an attorney or an I & A officer on March 14, 1994, but did not see the I & A officer until more than five years from the date of injury. The Board stated that assuming the
I & A officer's silence was agreement with the attorney's statement that it was too late to file a timely application for the specific injury, that advice was correct. There was no evidence that applicant relied to her detriment on advice offered before the statute ran on May 21, 1998.

The panel granted reconsideration and rescinded the WCJ's Finding of Fact and substituted a finding that benefits were last furnished in 1994. The application was filed more than five years from the date of injury, and there was no equitable basis for tolling the statute of limitations.

3. *Morris v. Insurance Company of the West* (2002) 30 CWCR 304 (Board Panel Decision).

Applicant was employed as a professional football player by the St. Louis Cardinal football team from 1976 to 1984. From October 9, 1984 through December 16, 1984, the Applicant played for the San Diego Chargers football team. Although he had been frequently injured while playing for the Cardinals, he was examined by an orthopedic surgeon before playing for San Diego and cleared as physically fit to play professional football.

While playing for the Chargers, his aches and pains worsened, but he continued to play. His shoulders, elbows, back, legs and a broken finger were treated by the team trainers and doctors with whirlpool, ice, ultrasound and anti-inflammatory medication. He missed some time from practice. At the end of his one season with the San Diego Chargers, he retired from professional football. The employer never informed him that he might be entitled to workers' compensation, but, in 1998, an attorney told him that he could have a claim.

On April 1, 1998, the Applicant filed an Application for Adjudication of Claim for a cumulative injury to his spine and upper and lower extremities while employed by the St. Louis Cardinals and the San Diego Chargers during a 12-year period culminating on December 31, 1984.

The Applicant elected to proceed against San Diego. Defendant, Insurance Company of the West, filed an Answer denying injury and raising the statute of limitations as a defense. The Applicant was examined by two QMEs, who both reported that Applicant had sustained a cumulative injury from repeated trauma during his professional football career.

The matter proceeded to hearing. Medical evaluations and other documents were received in evidence. Applicant, the only witness, testified, among other things, that he had no knowledge of workers' compensation until a friend told him about it in December, 1997.

On a form required to apply for benefits from the League Player Retirement Fund, he checked “no” in response to a question asking if he had ever applied for workers' compensation. When questioned about the retirement form, he said that his daughter helped him fill it out. He was not assisted by an agent or attorney.

The WCJ found that Applicant sustained a cumulative injury that resulted in permanent disability of 85 3/4 percent, that payment of P.D. had been unreasonably delayed, and defendant was estopped from asserting the statute of limitations. Defendant filed a Petition for Reconsideration. Reconsideration was granted to give the Board an opportunity to study the law and facts further. After completing its study, a workers' compensation panel upheld the decision of the WCJ.

As to the statute of limitations, the Board first indicated that L. C. §5405 requires that claims be filed within one year after the date of injury. On the date of injury, L. C. §5402 required the employer to notify injured workers that they might be entitled to benefits on receiving knowledge of an injury from any source.

AD Rule §9816 specifically required such notice whenever a disability lasted more than three days. The purpose of the rule was to preserve the right of employees who might be ignorant of workers' compensation procedures. If an employer fails to comply with the notification rule, it will be estopped from pleading the statute of limitations as a defense. In this case the Board went on that Applicant's testimony was that he was injured and lost practice and game time.

He was treated by the employer's doctors and trainers. His testimony clearly established that his disability exceeded three days. In the opinion of the Board, although the employer obviously had sufficient notice of Applicant's injuries to investigate the facts, it did not advise him of his rights to workers' compensation. The employer's failure to give the proper notice estopped the employer from asserting the statute of limitations defense. The panel indicated they were not persuaded by defendant's argument that even though the employer furnished treatment, it did not have knowledge of a cumulative injury. In the opinion of the Board, the football team had other workers' compensation claims against it before Applicant's injury and cannot be said to have been ignorant of its duty to provide notice to the Applicant. Although the Applicant was aware of his disability, he was uninformed about workers' compensation law. The Applicant did not have the requisite knowledge to cause the statute of limitations to run against him.

The date of injury in a cumulative trauma case is the date of disability plus knowledge. In this case, the Applicant did not have the requisite knowledge as required under L.C. §5412. The panel also rejected defendant's laches argument indicating that Applicant cannot be charged with delay in asserting his claim because he had no knowledge that he had one. As soon as the Applicant became aware of his right, he promptly sought legal assistance and filed a claim. The panel then turned to the question of whether there was a

single cumulative injury as found by the WCJ or multiple injuries as urged by the defendant. The panel indicated that when distinct periods of injury occurred during the cumulative exposure period, there are separate and distinct cumulative injuries. On the other hand, one or more injuries may arise from the same event or separate events. The number and nature of injuries are a question of fact for the WCAB. If the victim of a C.T. returns to work and the disability increases, the question of fact is whether the increase is the result of the old injury or a new injury. The factual issue is determined from the events leading to the injury, the claimant's medical history and the medical opinion. Applying the law to the facts of this case, the Board indicated that both QMEs concluded that Applicant sustained one continuing trauma injury during his football career. One of the QMEs commented that Applicant's body had been subjected to extreme and extraordinary abuse causing wear and tear. The doctor's clinical findings were consistent with long-term stress-and-strain injury. The Board concluded that the WCJ's finding of a single cumulative injury was justified by the evidence.

The defendant also petitioned for reconsideration contending that the WCJ erred in not making an award against the St. Louis football team. The panel pointed out that L. C. §5500.5 provides that if a WCJ finds a cumulative injury, liability for the cumulative injury will not be apportioned to prior or subsequent years. In this case Applicant elected to proceed against San Diego, and the WCJ did not err in not issuing an award against St. Louis. Petitioner may be entitled to contribution from St. Louis, but that is properly the subject of a separate proceeding. The panel also indicated there was substantial evidence to support the WCJ's finding on permanent disability.

The Board went on to state that the WCJ did not err in finding that defendant unreasonably delayed P.D. advances. Both QMEs found Applicant had sustained a single cumulative injury that had caused P.D. Defendant had no reasonable doubt from a medical-legal standpoint about the P.D., and it's statute of limitations argument was without substantial merit.

The delay was unreasonable, and a L. C. §5814 penalty was proper. The panel affirmed the decision of the WCJ.

4. *Rivas (Hector) v. Safety-Kleen Corp.; Montiel (Hector) v. Safety-Kleen Corp*. (2002) 67 CCC 608.

The applicant became ill while employed by a salvage company where he used a solvent to degrease motor vehicle parts. A medical doctor diagnosed kidney failure and asked him about the chemicals he used at work. He showed the doctor a list of the chemicals he used which he had copied from the label on a solvent can. The doctor advised him to stay away from the solvent, and he complied. In November, 1995, he received a kidney transplant. In September, 1995, he consulted an attorney who filed a Workers' Compensation claim alleging injury to his kidneys due to repetitive exposure to toxic fumes, gases and liquids. On April 3, 1998, he filed a suit for personal injury damages against the manufacturer and the supplier of the solvent.

A co-worker, who used the same solvent, became ill in January 1996. He was treated at a hospital in Mexico where he was advised he had kidney failure due to exposure to the

solvent. On April 26, 1996, he filed a Workers Compensation claim alleging internal injuries to his kidneys and headaches. He filed a suit for personal injury damages on April 29, 1997, and received a kidney transplant in 1998.

The Superior Court judge granted the defendant's motion for summary judgment in both cases on the ground that they were barred by the one-year statute of limitations. Both injured workers appealed. The DCA concluded that the claims were barred by the Statute of Limitations under CCP §340(3).

The Court held that a complaint for personal injury must be filed within one year from the date the cause of action accrues. A personal injury action accrues on the date of injury or on the later date when the plaintiff becomes aware of an injury and its negligent or wrongful cause. Citing the case of *Jolly v. Eli Lilly & Co.* (1998) 44 C3d 1103, the Court noted the cause of action accrues when the plaintiff at least suspects, or has reason to suspect, a factual basis for its elements. The one-year period begins to run when the plaintiff suspects or should suspect that someone has done something wrong to him or has notice or information of circumstances to put a reasonable person on inquiry.

The person who has a suspicion of wrongdoing, but is not aware of the specific facts necessary to establish his claim, must go find the facts. He cannot wait for the facts to find him. He is bound by both his actual knowledge and by knowledge that could reasonably be discovered through investigation of sources open to him.

Here the plaintiffs knew their kidneys were malfunctioning. Rivas knew this in 1991. He had reason to suspect this was caused by exposure to the solvent. He gave a list of its contents to his doctor who told him to stay away from it. The Court held this alone should have been sufficient to arouse a reasonable person to further investigate. Also, Rivas filed a Workers' Compensation claim in September, 1996, attributing his condition to toxic exposure. The Court says Rivas' cause of action accrued no later than September, 1996, but his personal injury complaint was not filed until April, 1998, beyond the one-year Statute of Limitations.

The workers in this case argued that the three-year Statute of Limitations in CCP section 338(d) should apply because the solvent suppliers were guilty of civil fraud by failing to disclose the toxic nature of the product and the risk of exposure to it. The Court responds that the essence of the claims here is that the workers were injured by a defective product, even if the alleged defect was that the label gave an inadequate warning and gave inadequate instructions on how to use the product. In short, this is a typical product liability case.

The plaintiffs also argued that federal rules should be applied here, but the Court found them to be wholly inapplicable.

The injured workers failed in their responsibility to timely investigate and file their personal injury claims.

XXIV Contribution

XXV Subrogation, Third Party Actions

XXVI Credit, Restitution, Fraud

1. *Christian v. W.C.A.B.,* (2002) (writ denied) 67 CCC 455.

Applicant sustained an admitted industrial CT to both upper extremities. Applicant was awarded 15 months of TD at $360.55 per week and $47,601 in PD benefits. Defendant paid the benefits along with attorney fees. Five days after the benefits were paid, defendant faxed a letter to applicant's attorney confirming a conversation they had the previous day in which defendant advised the attorney was filing a petition for reconsideration. Defendant requested applicant's counsel return the attorney fees and have applicant return the benefits paid. Defendant filed the petition for reconsideration. The WCJ rescinded his Findings & Award. Defendant again requested the funds be returned. Applicant's attorney sent a letter to defendant in which he refused to return the fees or the benefits check. The letter stated that the defendant would be entitled to receive all or part of the money back if the WCJ changed his opinion and acknowledged that she advised applicant that money may have to be returned. Neither the fees nor the benefits were returned.

The WCJ issued a new Findings & Award awarding $1,155 in PD benefits and attorney fees of $200. Applicant petitioned for reconsideration, which was denied. Defendant filed a petition for reimbursement. The petition was granted. Applicant filed a petition for reconsideration, contending in relevant part that it was inequitable to order reimbursement when defendant paid applicant pursuant to a valid award and there was no wrongdoing or bad faith on the part of the applicant. The applicant relied on *County of Sacramento v. WCAB (Stapp),* 64CCC 788 (writ denied), in which the WCAB found that if a defendant pays an award before the award is final and that payment was made without any wrongdoing or bad faith on the applicant's part, then reimbursement of funds is not required.

In his Report and Recommendation on Reconsideration, the WCJ recommended that reconsideration be denied. The WCJ distinguished the facts in *Stapp* from those in the instant matter, noting that, in *Stapp,* the WCAB found no evidence the applicant or applicant's counsel was aware that the benefits were not owed or that either of them acted in bad faith. However, applicant in the present case knew within a few days after the payment that the award was not final because defendant was going to appeal. The WCJ had little doubt that contents of the defendant's letters and the conversation requesting reimbursement were immediately conveyed to the applicant. The attorney admits that she told the applicant of the defendant's request, but she does not say how quickly she did so. Although applicant's counsel assured the defendant that its money would be returned, depending on the outcome of the trial, not even the fees have been returned. The applicant argued that she spent the money on living expenses, but in fact she paid $10,000 to her boyfriend of seven years, $3,000 to an aunt, $5,000 to her parents, and $5,000 to two credit companies. She also paid business expenses. She testified that she was living rent free at the time she was spending the money.

The WCJ concluded that it was most probable that the applicant was immediately advised of defendant's request for reimbursement and that she knowingly used the money to pay debts and defray business, living, and recreational expenses until it ran out. The WCJ did not believe the applicant's claim that she was not told they wanted the money back until after it was spent. The WCAB denied reconsideration and adopted and incorporated the judge's report without further comment. The writ was denied.

2. *Farmers Insurance Group of Companies/Truck Insurance Exchange v. WCAB (Sanchez*), Court of Appeals, Second Appellate District, Certified for Publication, filed December 19, 2002. 67 CCC ____.

Applicant injured his right lower extremity and psyche while employed as a security guard. He was awarded 73 3/4 percent permanent disability amounting to $28,787.50, payable at $70 per week and thereafter a life pension of $22.21 per week, as well as further medical treatment.

The applicant was entitled to reimbursement for expenditures he made to acquire special footwear that he needed as a result of his injuries. Each pair of shoes cost $1,300. The applicant submitted stolen purchase slips from a defunct store which he then forged. Over a three-year period, the applicant pocketed $84,527.56 from the fraud. The applicant was prosecuted under Insurance Code §§1871.4 and 1871.5. He pled no contest. The Court ordered him to pay restitution of $84,527.56 at the rate of $100 per month. Applicant had made no payments to Farmers on the Court-ordered restitution.

Farmers filed a petition to bar all further workers' compensation benefits based on the fraud conviction, or in the alternative, for credit. Farmers cited *Tensfeldt v. WCAB* (1998) 63 CCC 973. Applicant argued he should not be barred from further benefits and no credit should be allowed.

A WCJ found all benefits were not barred and that Farmers was entitled to a credit against future medical treatment but not against the life pension. The WCJ suggested that the future receipt of medical treatment and supplies could be barred if Farmers had filed such a request within five years of the date of injury. The WCJ concluded he did not have jurisdiction to reopen the award beyond that time.

Farmers' Petition for Reconsideration contended credit may be allowed against a different specie of benefits. Farmers distinguished Tensfeldt*, arguing that credit is not the same as barring further recovery.*

In his report on reconsideration, the WCJ reasoned, based on *Tensfeldt*, that in as much as the fraud pertains solely to the medical award, Farmers' right to a credit also was limited to Sanchez's receipt of medical benefits. The Board denied Farmers' Petition for Reconsideration and adopted the WCJ's report in its decision.

Farmers no longer contends the applicant should be barred from receiving all benefits. Farmers contended before the Court of Appeal that it is asking only for restitution from any source available, of money fraudulently obtained. Farmers argued that while

Tensfeldt prohibits barring a benefit that was not the subject of the fraud, it does not address restitution and credit rights. In support of its argument, Farmers cites decisions where credit for overpayment of one specie of benefit has been allowed for liability against another.

Farmers sites specifically the case of *Safway Steel v. IAC* (1942) 7 CCC 282 for the proposition that credit should be allowed in this case. In the *Safway* case, the Court reasoned that compensation paid to an injured worker under the mistaken belief the worker was entitled to such payments was the equivalent of furnishing the injured worker with living expense advances. By allowing a lien against unpaid compensation, the *Safway* court effectively allowed a credit against future compensation, whatever the specie. *Safway* and the other cases cited by Farmers permitting restitution from any benefit due, did not involve workers convicted of fraud and restitution ordered pursuant to Insurance Code §§1871.4 and 1871.5. Moreover, a lien claim of living expense is as vastly different from the criminal penalty of restitution. While the WCJ may reduce the lien pursuant to a settlement agreement, he has no power to modify or compromise a criminal restitution order absent a specific agreement to that effect. Allowing Farmers a credit against applicant's life pension would be tantamount to a modification or compromise of the criminal restitution order. They therefore declined the request.

Farmers also cites *Moreno Valley Unified School District v. WCAB* (1996) 61 CCC 1214, for the proposition that the Board may not interfere with restitution ordered by the Superior Court. Farmers implies the Board must see that the applicant pays the restitution order. In *Moreno Valley*, the parties had settled the injured worker's claim by a Compromise & Release agreement prior to a criminal conviction under Ins. Code §1871.4. The Superior Court ordered the applicant to pay a hundred dollars total in restitution pursuant to Ins. Code §1871.5. The Moreno Valley Unified School District sought to recover the $100 plus $109,000 it claimed the worker's fraud had cost it. The school district requested an order from the Board setting aside the settlement. The Board held that it could not interfere with the Superior Court's order of restitution, and moreover, the school district had not met its burden of proof on the $109,000. The Board commented that restitution was a remedy only obtainable in criminal proceedings, and the Board's role was limited to questions regarding provision of the benefits, post conviction.

Based on the foregoing, the Court was of the opinion that Farmers' remedy in this case lies in civil proceedings to enforce the judgment through wage garnishment and other means of collection available to judgment creditors.

On a related note, L. C. §5803 allows the Board to reopen a prior award more than five years after the date of injury upon a showing of good cause. Whether there is good cause depends on the circumstances of each case and is discretionary with the Board, but the Board's determination is not conclusive. Fraudulent misrepresentation has been held good cause to reopen. Moreover, L. C. §5803.5 provides that a conviction pursuant to Insurance Code § 1871.4 that materially affects the basis of any order, decision, or award of the Board is sufficient grounds for reconsideration of that order, decision, or award.

The Court therefore concludes that the Board had discretion to reopen an award normally barred by L. C. §5803 on the basis of a conviction pursuant to Insurance Code §§1871.4 and 1871.5. In accordance with Insurance Code § 1871.5 and *Tensfeldt*, the convicted worker is barred from receiving further compensation directly stemming from the fraud. Applicant's fraud pertained only to obtaining reimbursement for shoes never ordered. Since the employee is entitled to continue to receive the benefits which were not part of the fraud, the only reimbursement for further purchases of shoes should be barred, but other reasonably necessary medical treatment should continue. Similarly, a credit against other medical treatment is an impermissible bar of benefits not directly emanating from the fraud.

The decision of the Board is annulled and the matter remanded.

3. *People v. Moreno* (2002) 67 CCC 1461 (Nonpublished).

Sanchez, an employee of a temporary company, had been sent by that company to work at a food plant. Instead of reporting to the food plant herself, she sent Moreno to do the job. Moreno, representing herself as Sanchez, worked at the plant for three days before becoming injured. Moreno represented herself as Sanchez to the surgeon who treated her each time she saw him, and Sanchez assisted her in filling out paperwork in the latter's name at the doctor's office. Sanchez pretended to be injured when she went to the employment company to get insurance paperwork. With Sanchez's assistance, Moreno represented herself as Sanchez and signed Sanchez's name to an application for workers' compensation when she met the administrator at Sanchez's home. Before the fraud was discovered, $12,301.58 had been paid out for medical treatment and claim investigation.

The defendants moved to set aside the information, contending that the false representations by Moreno were not material, which was an essential element of the charged offenses. The trial court granted the motion, concluding that, under *Hunt Wesson Foods v. WCAB* (1983) 48 CCC 878, the true identity of a workers' compensation claimant is irrelevant to his or her entitlement to benefits. Therefore, the fraud was not material. The Court further concluded that Moreno's true identity was irrelevant to apportionment, whereby compensation will not be provided for that portion of the worker's injury which was related to a pre-existing condition. The Court concluded that the insurance company became aware of Moreno's true identity in sufficient time to permit it to determine if she had any such condition.

An appeal was filed on the trial court's ruling.

The Court of Appeal indicated that *Hunt Wesson* holds that compensation cannot be denied to an injured worker merely because he or she is identifying themselves as someone else. A misrepresentation is material if it is capable of influencing an insurer's decision to pay or withhold benefits. Under *Hunt Wesson* an insurer may not deny benefits to a worker injured in the line of duty because the worker has falsely identified himself or herself. If the insurance company cannot deny benefits on this basis, the basis cannot be capable of influencing the insurer's decision to pay or withhold benefits. Therefore, the representation is not material.

On appeal, the People raised the issue that Moreno's representation that she was Sanchez interfered with the insured's ability to apportion her injury and therefore was material. The Court of Appeal indicated that, as the trial court correctly concluded, apportionment was a non-issue in this case, as the insurance company discovered Moreno's identity in sufficient time to determine if she had any pre-existing conditions which would serve as a basis for properly denying a portion of her compensation.

The People next argued that the issue of the misrepresentation was material because there were two potential employers, the employment company and the food plant. The Court points out, however, that they confuse apportionment with the concept of joint and several liability on the part of the two potential employers involved. Whatever her true name, Moreno worked for either or both, and they must determine whose employee she was. This issue is completely irrelevant to what name she called herself.

Finally, the People, in their appeal, argued the *Tensfeldt v. WCAB* (1998) 63 CCC 973 case for the proposition that a worker may be convicted of fraud and still be entitled to workers' compensation benefits. While *Tensfeldt* allowed for the possibility that a worker could be convicted of fraud in connection with a particular injury and still receive compensation for it, it did not so hold because the particular issue was not before it. *Tensfeldt* held that, pleading guilty to fraud, the worker necessarily admitted that his claim that the knee injury was industrial or work-related was material, which, of course, was the case. To whatever extent *Tensfeldt* may be relevant to this case, the Court wrote, they doubted that it is, it was distinguishable. Unlike *Tensfeldt*, in this case Moreno did not lie about how she came to be injured. The Court went on to say that the applicant in this case did not lie about the very fact of compensability, which is the trigger under *Tensfeldt*. In this case, it was beyond dispute that Moreno was injured in the job.

The Trial Court's ruling was, therefore, affirmed.

4. Wilson v. National Union Fire Insurance Company, (2000) 30 CWCR 217 (Board Panel Decision).

Applicant injured his back in the course of his employment and was awarded 26% permanent disability. Following the Findings & Award, the Applicant was seen by an agreed medical examiner, who felt a functional capacity evaluation was needed to get a better picture of Applicant's permanent disability.

Applicant filed a petition to reopen claiming new and further disability. Defendants resumed advancing permanent disability. The functional capacity test that was suggested by the AME was performed by a physical therapist who concluded that the Applicant was exaggerating his disability. The agreed medical examiner then submitted supplemental reports to the effect that Applicant's PD was no different than it was when the Findings & Award was issued.

Following trial, the WCJ found Applicant had increased permanent disability from 26% to 33-1/4%, and that the Applicant had been overpaid $11,173.18, which was allowed as

a credit against all future benefits, including future medical treatment. Applicant filed a petition for reconsideration contending that the credit should not have been allowed against the medical award because the credit defeated the purposes of awarding it and the Labor Code requirement that medical treatment be provided.

In his report and recommendation on reconsideration, the WCJ indicated that the Applicant had unclean hands. In the opinion of the judge, the overpayment was created by Applicant's actions, and he cannot expect to benefit from those actions. The judge indicated that although the Applicant indicated he did not ask for the advances, he filed a petition for penalties for not making payments, and Defendants began advancing permanent disability after that petition was filed. In the opinion of the WCJ, to deny credit against medical care would result in a windfall to the Applicant.

In a 2-to-1 decision, the majority upheld the WCJ. The Panel majority noted that the credit for overpayment of PD may be allowed if warranted. Such credit has been allowed where PD was advanced, but none was owed. The Board Panel indicated that credit against future medical treatment is warranted when they are made in response to the Applicant's request. *Hofer v. WCAB*, (1996) 61 CCC 277 (writ denied).

The Board Panel noted that the Applicant requested payment of PD in excess of the amount Defendant had paid, and the payments were made due to Applicant's symptoms magnification. Denying credit under these circumstances would reward Applicant's behavior and penalize Defendants for making prompt payment in accordance with the AME's preliminary opinion. The Panel denied reconsideration.

In a dissenting opinion, the Commissioner indicated that allowing the credit against future medical treatment effectively negated Applicant's award of further medical treatment. The Commissioner indicated there were additional benefits against which the credit was allowed that afforded the Defendant an opportunity to recoup overpayment.

The Commissioner indicated that L. C. § 4909 provides that, in the absence of agreement, overpayments are not an admission of liability, and may be taken into account in fixing the amount of the compensation to be awarded. The use of the word "may" makes the credit discretionary with the Board. The Commissioner would have granted reconsideration and amended the Findings & Award to provide for credit only against PD, penalties, and wage loss benefits.

5. *Ybarra v. WCAB* (2002) 67 CCC 1282 (not certified for publication).

The applicant suffered several injuries while employed as a deputy sheriff for the County of Los Angeles. He received an award of 41% P.D. for a cumulative trauma injury involving his cardiovascular and gastrointestinal systems through July 1994, and he then received an award of 61% P.D. for a subsequent injury to his knee and shoulder in October 1997.

He applied for benefits from the Subsequent Injuries Fund (SIF), contending that the combination of injuries caused an overall P.D. of 81%. He also applied for a service-connected disability retirement from Los Angeles County Employees Retirement

Association (LACERA). He listed all of his injuries on the application. However, his retirement was granted solely on the basis of the orthopedic injuries to his knee and shoulder.

The applicant was awarded SIF benefits. In further proceedings, the WCJ held that the SIF is entitled to credit for sums received "from any source whatsoever" against its liability for benefits, with the WCJ relying on L.C. §4753.

The applicant filed a Petition for Reconsideration, contending that, while the SIF may be entitled to credit for the first award of 41% P.D., it is not entitled to credit for the proceeds of his service-connected disability retirement since that retirement was granted purely on the orthopedic disability and was unrelated to the earlier cumulative trauma injury. The WCJ did note, in his Recommendation on Reconsideration, that the records from the retirement proceeding revealed that the applicant requested retirement on the basis of both the orthopedic and internal disability. The WCJ pointed out that the internal disability is a part of the applicant's "prior disability," and therefore the SIF is entitled to their claim of credit against these benefits. The WCJ cited *Kehrer v. WCAB* (1999) 64 CCC 1302 (writ denied) in support of his opinion. Reconsideration was denied and the matter was appealed.

The Court of Appeal noted that the SIF argues that LACERA's disability retirement determination was not based solely on applicant's orthopedic disability since it considered the medical history that included applicant's cardio and gastrointestinal complaints and it reviewed an internal medical report prior to deciding to grant the disability retirement.

The Court reviewed the LACERA records and noted that the decision to grant the disability retirement was based solely on the orthopedic report. The Court said that neither the applicant's retirement application, nor any other factors, amount to substantial evidence to support the Board's conclusions when compared to the LACERA staff recommendation. Accordingly, the Court annulled the Board decision and remanded the matter.

XXVII Special Benefits, Including Discrimination Under L. C. §132(a).

1. Coulter v. WCAB (2002) 67 CCC 1013 (Not Certified for Publication).

Applicant was injured on September 28, 1992 and continued working until December 17, 1992, when his treating physician placed him on temporary total disability. He was terminated on April 30, 1993, while on temporary disability which resulted in his filing a L. C. § 132a petition. In 1994, the employer's insurer and Applicant agreed to Applicant's continued temporary disability, and back surgery was authorized. Applicant was declared permanent and stationary in July, 1996, by his treating physician, prompting the insurer to petition to terminate temporary disability. Because Applicant was still enrolled in a work evaluation to determine vocational rehabilitation feasibility, the petition to terminate temporary disability was opposed. After an attempt at

vocational rehabilitation, it was evident that Applicant was not employable due to his disability. The parties entered into a compromise and release in March of 1998 for $86,250.00, but the settlement did not resolve the L. C. § 132a issue.

In July 1999, a trial of the L. C. § 132a issue took place, and the WCJ, siding with Applicant, determined that because his termination occurred while he was on temporary disability, the L. C. § 132a claim was found to be meritorious. Lost wages and increased compensation in the amount of 50% up to $10,000.00 was awarded. Defendant's Petition for Reconsideration was denied, since at the time of the termination there was no evidence that Applicant would not ultimately be able to return to work in his former capacity. Similarly the Petition for Writ of Review was denied and attorney's fees were awarded pursuant to L. C. § 5801.

On May 23, 2001, the WCJ instructed Applicant to submit a written petition to reduce the Findings and Award of March 28, 2000, to a sum certain; lost wages, among other benefits, from April 30, 1993, to April 30, 2001, at $400.00 per week were requested and the matter submitted without testimony. The WCJ found that Applicant did not meet his burden of proof on the issue of lost wages because he did not show that the employer's discriminatory act of terminating him proximately resulted in lost wages. In the Opinion on Reconsideration, the WCJ dismissed Applicant's contention; that if the employer had complied with the American's With Disabilities Act (ADA) by making a reasonable accommodation he would have been employable, and would have lost wages. Instead, the WCJ noted that Applicant did not prove that light duty was available or that he was ever released to perform light duty; Applicant was never able to return to the open labor market. Applicant filed a Petition for Writ of Review.

On appeal, the court was left to decide whether it was error to refuse to award lost wages during the period Applicant was being paid temporary disability or the subsequent period when Applicant was declared permanent and stationary, but unable to resume his prior duties.

Citing *Dyer v. WCAB* (1994) 59 CCC 96, the court concluded it was not error to refuse to award lost wages. Lost wages are remedial in character and limited to those lost wages and benefits caused by the acts of the employer; lost wages are not awarded when an employee is not ready, willing or able to perform the duties of his or her position. When an employee is collecting temporary disability, he or she is presumed unable to work and therefore unentitled to compensation for lost wages. Applicant was paid temporary total disability through March, 1998, when the Compromise and Release was entered into and, thereafter, could not participate in the open labor market in any capacity. The court found no credible evidence in the record to indicate Applicant was capable of returning to work in any capacity following his termination.

After commenting that there is no authority to confer jurisdiction on the Appeals Board for ADA claims, the court concluded that even if jurisdiction were appropriately before the Appeals Board, Applicant would not, under the circumstance of this case, be entitled to recover. To state a prima facie case under the ADA, a plaintiff must prove that he is a qualified individual with a disability who suffered an adverse employment action because of his disability, at which time the burden would shift to the employer to establish

whether reasonable accommodation is available. Since the evidence in this case established that Applicant could not perform any employment function and Applicant did not identify any position with his employer that he could essentially perform, Applicant did not meet the burden of proof under the ADA.

2. *Logan v. West Management Company* (2002) 30 CWCR 275 (Board Panel Decision).

Applicant sustained fatal injuries in the course of his employment as a condominium doorman when he drove a tenant's automobile into an open elevator shaft and plunged to the bottom of the pit. An application was filed for death benefits and increased compensation based on alleged serious and willful misconduct of the employer. The normal issues were resolved by stipulated award. The matter proceeded to trial on the issue of serious and willful misconduct of the employer. The evidence established that the building in which the decedent worked had 36 condominium units. There was an adjacent four-story parking structure in which the tenants' automobiles were parked and their personal property stored.

Vehicles were transported to the various levels of the structure by an elevator, the gates of which had a safety mechanism to keep them closed when the elevator car was not at the same level. Although the tenants had assigned spaces, they were not permitted to park their own cars, but left them in the driveway to be parked by the doorman on duty. The normal procedure was for the doorman to drive the vehicle to the elevator gate, get out and open the gate, drive the car into the elevator, close the gate, and take the elevator to the desired level where the gate would again be opened and closed. Jeremy West testified that he supervised the doorman. He occasionally discovered a stop inserted in the mechanism, permitting the elevator to operate even if the gate was open. He removed the stop each time and instructed the doorman not to disable the safety device. In addition to himself, only the doorman and two designated tenants were authorized to use the elevator. The decedent told him after the accident that a tenant left his car at the entrance to the parking structure and the elevator gate was open. Apparently thinking the elevator gate was on the ground floor, he drove the car into the shaft, plunging 18 feet. The WCJ, after hearing the evidence, found that the injury was not caused by the employer's serious and willful misconduct. In his opinion the WCJ indicated that serious and willful misconduct must be one intentionally performed either with knowledge that serious injury is a probable result or with a positive, active or wanton, reckless and absolute disregard of its possible damaging consequences. Although the Court in *Rogers Materials v. IAC (Drake)* (1965) 30 CCC 421, held that a finding of willful misconduct can be supported by evidence that the employer was aware of the likelihood that an employee would be injured unless precautions were taken and deliberately failed to take necessary precautions, in this case Applicant had not established that the supervisor had deliberately failed to take reasonable corrective action. The WCJ reasoned that the supervisor instructed the doorman and the chief doorman not to override the safety mechanism each time that he discovered a stop in it. In the opinion of the WCJ, he did not evidence malice, recklessness, or indifference to the risk, nor was it unreasonable for him to expect that his orders would not be followed. His failure to take additional disciplinary action or to install a tamper-proof safety mechanism did not exceed gross negligence. Applicant filed a Petition for Reconsideration. In his report and

recommendation, the WCJ said he thought that the supervisor had a good faith belief that removing the stops and ordering the doorman not to insert them would suffice. In the opinion of the WCJ, an employer may successfully defend against an allegation of failure to take precautions by showing that they in good faith instituted a course of action reasonably believed to be effective. The WCJ further explained that under the circumstances of the present case he was satisfied that the measures taken by the supervisor were adequate. While he could have taken steps that the Applicant advocated, the WCJ was not persuaded that in order to avoid liability he was obligated to do so. The WCJ indicated that even the knowledge that the doorman had disobeyed his orders on 12 to 15 occasions over three or four years did not convince the WCJ that his measures were unreasonable. The supervisor could reasonably expect that the doorman would follow his instructions, conveyed directly, or through surrogates. Indeed, it appeared that they did, as there were only occasional violations during that time. The supervisor was not required to discipline the employees in order not to risk liability. A Board panel adopted the reasoning of the WCJ and added that serious and willful misconduct is something much more than negligence, however gross. It is an intentional act with either knowledge that it is likely to result a serious injury or wanton disregard of its possible consequences. The Board felt the *Rogers Materials* case relied on by the applicant was distinguishable. In that case the employer repeatedly saw the employee in danger and merely told him to be careful. Here, however, the employer removed the stop every time he saw one and instructed the employees not to override the safety features. These admonitions and instructions without disciplinary action did not constitute serious and willful misconduct under the facts of this case. The panel denied reconsideration.

3. *Miller v. Fremont Compensation Insurance Company* (2002) (Board panel Decision) 30 CWCR 100.

Applicant received fatal injuries arising out of and occurring in the course of his employment. He left no dependents. The burial expenses were paid by his father. The father was reimbursed by Fremont Compensation Insurance Company. The father filed an Application for Adjudication of Claim of Death Benefits because of decedent's fatal injuries. The Department of Industrial Relations was joined as an additional applicant pursuant to L. C. § 4706.5 because it appeared that the decedent had not left any dependents. On January 28, 2000, the decedent's father and mother filed an application claiming increased benefits because the injury had been caused by defendant's serious and willful misconduct. Five weeks later, the DIR filed a similar petition. The death benefit was ordered paid to the DIR.

The defendant filed a motion to dismiss the S & W misconduct application. At the conference, the parties agreed to submit the issues on the S & W to the judge. They agreed to submit the issue of whether the parents or the DIR would be entitled to the S & W misconduct benefits and whether the claim was timely filed. The issue of whether the injury was caused by S & W misconduct was deferred. The WCJ found that when an employee, without dependents, dies as a result of serious and willful misconduct of his employer, neither his heirs, nor his estate, are entitled to the benefits under L. C. § 4553. The judge further found that when an employee without dependents dies as a result of serious and willful misconduct, the Department of Industrial Relations Death Without

Dependents Unit is entitled to the benefits under L. C. § 4553. The judge also found that the timely-filed Petition for Benefits for Serious and Willful Misconduct filed on behalf of the parents served as the timely filing for the Department of Industrial Relations Death Without Dependents Unit. The parents petitioned for reconsideration.

L. C. § 4700 provides that if there are no dependents, any accrued and unpaid compensation shall be paid to the personal representative of the deceased employee, heirs, or other persons entitled thereto without administration. L.C. § 4702(a) provides that except as otherwise provided in this section and L.C. §§ 4553, 4554, 4557 and 4558, the death benefits shall be paid to specified dependents. L. C. § 4706.5 provides that if a fatally injured worker does not leave any person entitled to a dependency death benefit, the employer shall pay a sum to the DIR equal to the death benefit that would be payable to a totally dependent surviving spouse with no dependent minor children. If the deceased employee leaves no personal representative, heir, or other person entitled to the accrued and unpaid compensation under L. C. §4700, the accrued and unpaid compensation shall be paid by the employer to the DIR. Finally, L. C. § 4553 provides that if the injury is caused by the serious and willful misconduct of the employer, the amount of compensation otherwise recovered shall be increased one half, together with costs and expenses not to exceed $250.

The Board indicated that, applying these principles to the facts before it, the panel said that when an injured worker dies, any accrued compensation would be subject to the increased compensation provided in L. C. § 4553 for S&W misconduct. Implicit in the WCJ's conclusion, that the S&W claim survived the death was the concept that the S&W cause of action accrued at the instant of the injury. An obligation that survives an injured worker's death is an asset of his or her estate, and it can be recovered only by the executor or administrator of the estate. As a general rule, a cause of action accrues when the wrongful act is done. Unless otherwise provided by statute under Code of Civil Procedure § 377.20(a), a cause of action for or against a person survives. In this case, the panel continued, the cause of action accrued at some finite time, perhaps seconds or minutes prior to death. Thus, the S&W cause of action accrued before death, and according to L. C. § 4700, passed to the personal representative of the deceased employee or heirs or other persons entitled thereto without administration. Although L. C. § 4700 specifically mentions only disability indemnity and medical expenses, L. C. § 4553 says that the amount of compensation otherwise recoverable shall be increased. As defined in L. C. § 3207, the term "compensation" includes permanent disability indemnity and medical expenses, among other benefits. Therefore, any increase in compensation awarded because of the employer's S&W misconduct is compensation accrued at the time of death and goes to the personal representative of the deceased employee or heirs or other persons entitled thereto pursuant to L. C. § 4700. The panel noted that death benefits are payable to the DIR only in strictly defined circumstances. There is an implicit limitation in L. C. § 4706.5 that the only benefit payable to the DIR is the described death benefit. An S&W award is not a death benefit. The panel observed that if a deceased employee had lived to obtain an S&W award, it would have been part of his estate. The panel could see no reason to treat the case before it any differently.

In view of the conclusion that any S&W award would not go to the DIR, the panel deemed the parents' attorney's claim for costs and fees under L. C. § 5811 and Code of Civil Procedure §1021.5 to be moot. Accordingly, the panel rescinded the WCJ's conclusions of law and substituted a finding that if an employee without dependents dies as a result of the employer's S&W misconduct, the employee's heirs or estate are entitled to L. C. § 4553 benefits, the DIR is not entitled to the L. C. § 4553 benefits, and the parents' petition for S&W benefits was timely filed.

XXVIII Penalties, Sanctions & Contempt

1. *Bosell v. W.C.A .B.* (2002) (writ denied) 67 CCC 447.

Applicant sustained an admitted injury to his chest, ribs, neck, spine, right shoulder and upper extremity on 3/20/97, when a reel of cable weighing approximately 16,000 pounds rolled forward, pinning him between it and another reel. The underlying workers' compensation claim was resolved by C&R. Applicant also filed an application for benefits for S&W under Labor Code §§ 4553 and 4553.1

At the hearing on the S&W, applicant offered his own testimony and introduced a copy of the decision of the ALJ of the Cal/OSHA citation given to defendant by the Cal/OSHA safety inspector in connection with applicant's injury, which was upheld as a serious violation of §3241 (c) of the General Industry Safety Orders (GISO).

Defendant presented testimony by various co-workers and others that tended to show that applicant and his co-workers had been trained to chock the cable reels to prevent them from rolling. Defendant's evidence tended to show that occasionally cable reels were allowed to stand without chocks, but that during an 18-year period before applicant's injury, rolling cable reels had hurt no other worker.

The WCJ issued an F&O, holding that applicant take nothing by way of his petition for S&W, and further indicated that the WCJ had "serious and significant doubts as to the credibility of the applicant."

Applicant filed a Petition for Reconsideration, contending, in pertinent part, that defendant had inadequate safety practices, or that if safety practices existed, failed to enforce them. Applicant further contended that the OSHA investigation confirmed that a number of cable reels were inadequately secured and that inadequate material was used to chock the wheels. Applicant contended further that the violation of § 3241(c) of the GISO was additional evidence that defendant was guilty of S&W.

The WCJ recommended that the Petition be denied. The WCJ indicated applicant had failed to state fairly all of the material evidence as to the points at issue. The WCJ also noted that applicant's testimony was not credible.

On 12/4/01 the WCAB issued its Opinion and Order Denying Reconsideration. The WCAB pointed out that in order to support a holding of S&W by defendant based on a violation of a safety order, the WCAB must find all of the following:

2. The specific manner in which the order was violated.

3. That the violation of the safety order did proximately cause the injury or death.

2. That the safety order, and the conditions making the safety order applicable, were known to, and violated by, a particular named person, either the employer or a representative designated by §4553, or that the condition making the safety order applicable was obvious, created a probability of serious injury, and that the failure of the employer to correct the condition constituted a reckless disregard for the probable consequences.

The WCAB stated that applicant had established the first two elements, but had failed to prove the third element. There was no showing that defendant's failure to correct the condition constituted "reckless disregard for the probable consequences."

The WCAB noted that the terms "serious" and "willful" have a different meaning in workers' compensation settings than they do in the enforcement of Cal/OSHA citations. Violation of the safety order could be established by showing that defendant could have known of the violation with the exercise of "reasonable diligence." Within the workers' compensation setting, the WCJ must find that defendant's failure to correct the condition constituted "reckless disregard for the probable consequences." The WCAB cited *Mercer-Fraser Co vs. Industrial Acc. Comm* (1953) 18 CCC 3, wherein the Supreme Court stated that S&W misconduct cannot be sustained upon proof of mere negligence of any degree.

The WCAB pointed out the facts that defendant was unaware of any chronic problem with movement of reels and that no one had been injured in the 18 years the supervisor witness had worked with defendant. It was so rare that he had never thought of bringing it up in safety meetings.

The Petition for Reconsideration was denied, as was applicant's Petition for Writ of Review.

2. *County of Los Angeles v. WCAB (Jones*) (2002) 67 CCC 1105 (unpublished).

Applicant sustained an admitted injury while employed as a social worker by the County of Los Angeles. On 11/24/98 an Award issued finding temporary disability, permanent disability of 69%, and future medical care. The WCJ further found that defendant had unreasonably delayed the payment of temporary disability and permanent disability and awarded a 10% penalty on these species of benefits. Applicant's attorney was awarded fees of $8,696.00 plus 15% of the total amount of penalties.

There was a subsequent dispute over medical treatment which was resolved by Stipulated Award, which provided for an additional award of attorney fees of $900.00. On the same day the court approved another settlement with attorney fees of $2,850.00.

The settlement agreement provided that there would be no penalty or interest, if the award were paid within 30 days. Defendant did not timely pay the awards of attorney fees.

The issue presented was to which species the penalty would apply. Citing *State Compensation Insurance Fund v. WCAB* (1981) 46 CCC 347, the court held that attorney fees is a separate class of benefits. Thus, the award of penalty on attorney fees would apply to all prior awards of attorney fees.

3. *Curry v. W.C.A.B.* (2002) (writ denied) 67 CCC 179.

Defendant had been advancing indemnity at $230.00 per week. Based on a better prognosis in a report from the treating physician, they reduced the payment rate to $170.00 per week. The defendant did not give the notice of benefit reduction required by A. D. Rule §9812(c). The WCJ imposed a 10% penalty under Labor Code §5814 for failure to issue the notice of change. On Reconsideration, the Board noted that the reduced rate was the correct rate for the medical record at the time, and reversed the imposition of penalty. The Board noted that penalty under Labor Code §5814 may be imposed for unreasonable delay in payment of compensation, not for delay in furnishing benefit notice.

4. *Deakin v. WCAB,* (2002) (not published) 67 CCC 229.

Applicant was awarded benefits pursuant to Labor Code § 132a, his employer having discriminated against him for having claimed entitlement to workers' compensation benefits. The award which issued on 10/8/98, called for the employer to pay Applicant $10,000.00, less $2,000.00 to his attorney for fees. The award was paid, but untimely, which resulted in Applicant claiming penalties pursuant to Labor Code § 5814. At trial, the employer asserted that the delayed payments were not unreasonable because they did not have the financial ability to pay the award timely. Bank statements were entered into evidence showing a combined balance of $70,000.00 at the beginning of December 1998 and less than $10,000.00 by February of 1999 with negative balances much of the time.

The WCALJ found no penalty for the delayed payment because the employer did not have sufficient funds on hand to make the payment. Reconsideration was denied, and a writ of review was filed with Applicant arguing that there was no genuine medical or legal doubt that benefits were owed and that there was insufficient evidence to support the conclusion that the employer's financial state was precarious. The Court did not decide whether inability to pay was a defense to a Labor Code §5814 penalty, but instead concluded that there was insufficient evidence to conclude that the employer could not pay. Although diminishment in bank accounts inferred the inability to pay, there needed to be more evidence on what caused the reduction in available funds. The employer has the burden of proof on the issue of whether the delay in payment was reasonable, and they were obligated to show that the inability to pay was the result of legitimate business expenses rather than a misuse of funds or avoidable institutional neglect. Also, the employer must show a lack of requisite funds during the entire period of delay, not just some of the delayed period, leaving a gap in the evidence with regard to the employer's financial state during the remainder of the delay period.

The Court remanded this matter back to the WCAB with direction to award the 10 percent penalty for the delay in payment.

5. *Holzhauser v. WCAB* (2002) (writ denied) 67 CCC 841.

In a Findings & Award on a death case, the WCJ found injury AOE/COE and found decedent's widow and son were dependents and entitled to workers' compensation benefits.

Defendant paid the award, but applicant claimed it did not properly pay interest owed to the widow and also did not properly pay attorney fees. Applicant filed petitions for L.C. § 5814 penalties.

Following a trial, the WCJ issued a Findings & Award finding defendant unreasonably delayed paying the widow's benefits and awarded a L. C. §5814 penalty on the widow's benefits.

Applicant's widow and son filed a petition for reconsideration, contending penalties should have been awarded on the total death benefits awarded to both the widow and the son.

The WCJ recommended that the WCAB deny reconsideration. The WCJ indicated that defendant made separate payments to the widow and the son. The WCJ then stated the sole issue was whether the L.C. §5814 penalty should have been based on the overall compensation awarded to both widow and son, instead of on the widow's compensation alone. The WCJ found the penalty was assessed against the widow's compensation only, because only the widow's compensation was unreasonably delayed, not the son's compensation. The WCJ argued that death benefits are one class or specie of benefit to which penalty for unreasonable delay should attach. However, the judge felt that under the circumstance of the case, the award of benefits to the applicant and the award of benefits to the son were separate classes of benefits. Accordingly, a penalty was awarded only against the death benefit awarded to the widow, since her compensation was the only one unreasonably delayed.

The WCJ indicated that based on *Rhiner* and *Gallamore,* the penalty for unreasonable delay lies against the full amount of the class of compensation that was unreasonably delayed, even if a portion of that class of compensation was previously paid on a timely basis.

The WCJ noted that in the cases of penalties, a balance must be struck between the right of the employee to prompt payment of compensation and the avoidance of harsh and unreasonable penalties upon employer or carrier.

The WCJ stated that strictly applying the death benefit statute and analyses in *Gallamore* and *Rhiner,* the penalty would be applicable to all death benefits that are owed. However, the question in the judge's mind still remained one of striking a fair balance as cited above.

The WCJ indicated if one were to apply a penalty against the entire specie of benefit, then the question becomes who is entitled to that penalty. If the penalty is applied

against all death benefits awarded, then should the widow receive more than a 10 percent penalty as she was the only one whose benefits were unreasonably delayed? In the judge's opinion, it would not appear that such a result is called for under L.C. § 5814, since the statute requires the penalty represent 10 percent of the unreasonably delayed compensation. Similarly, if the WCJ went on to award the penalty to the son, it would appear to penalize the defendant excessively and in a harsh manner and unjustly enrich the son as all compensation due him was paid in a timely manner. Therefore, the WCJ opined that the fair balance test required that the penalty issue only against the class of benefits that was awarded to the wife.

The WCAB denied reconsideration and adopted and incorporated the WCJ's report without further comment. The writ was denied.

6. *Moore v. State of California, Department of Corrections,* (2002) (Board panel decision) 30 CWCR 162.

Applicant injured his right knee while employed as a correctional officer by the State of California on May 2, 1999. He immediately reported the injury to a supervisor and went to the infirmary where a nurse examined the knee. He filled out a form entitled "Employee's Report to Supervisor, Job-Related Injury," on which he checked the box stating the incident was a minor job-related injury and had not caused him to lose any time from work and he did not expect to need any medical treatment, other than first aid. The form provided that if any complication should develop as a result of the injury, the injured worker understands he will need to report that to his supervisor immediately. The injured worker continued working but saw his family doctor 5 days later complaining of right knee pain. He did not see the doctor again until August 16, 2000, when he complained that he could not run, kneel or squat on the knee. He was then referred to an orthopedic surgeon who operated on the knee on January 10, 2001, and was paid by applicant's private insurance plan. He was off work for seven weeks following the surgery. An application was filed, along with a claim form, on September 27, 2000. The application claimed that the knee disability and need for treatment was a result of the 1999 injury. A hearing was held before a WCJ. Among the exhibits was a QME report that concluded applicant's disability was not caused by the 1999 incident. The applicant testified at hearing he was afraid to tell his supervisor about his visit to his family doctor on May 7, 1999 because he thought it would affect his job. The claims adjuster testified the employer was notified of the incident when it occurred, but the injury did not require any medical treatment. She refer to the incident report as a "Band-Aid" report because the reported fall did not require medical treatment. The WCJ issued a Finding and Award that the injury caused 38 percent permanent disability, was presumed compensable pursuant to L.C. §5402(b) because it had not been denied within 90 days after May 2, 1999, and by placing injury in issue, the employer engaged in bad faith actions or tactics that were frivolous or solely intended to cause unnecessary delay.

The Board panel found merit in defendant's arguments. First as to L. C. § 5813(a) sanctions, the Board concluded that the facts before the Board did not justify that the defendant acted in bad faith or used tactics that were frivolous or solely intended to cause delay when it placed injury in issue. The panel concluded that the May 2, 1999, incident was treated as a "Band-Aid" event by the nurse on duty at the prison where the applicant

fell. Applicant continued to work thereafter and did not convey to the defendant that he had sought medical advice a few days later. Defendant had no reason to believe the nurse's interpretation was inappropriate; the injury did not require medical treatment beyond first aid. Applicant did not claim compensation until 1½ years later. At that time the defendant obtained an opinion from a QME that the fall had not caused applicant's disability, and, therefore, the defendant did not act in bad faith when it raised injury as an issue. The panel further concluded that the first aid rendered on May 2, 1999, did not constitute notice of an industrial injury so as to invoke the provisions of L. C. § 5402.

The panel granted reconsideration of the Findings and Award, amended the Findings on the presumption and sanctions to provide that the L.C. § 5402(b) presumption and L.C. § 5813 sanctions were inapplicable and affirmed the amended Findings and Award as its decision after reconsideration.

7. *Navarro v. A&A Farming* (2002) (WCAB En Banc) 67 CCC 296.

The applicant was employed by A&A Farming as a foreman. During his nine years of employment he sustained three back injuries which included a cumulative trauma injury for the period August 6, 1996 to April 5, 2000. After surgery he attempted to return to work, but was unable to perform the job duties, and he has not worked since. The insurance carrier provided temporary disability indemnity and medical treatment.

The employer was a member of Western Growers Assurance Trust which provides medical and other benefits to employees of the member employers. The trust is funded by both employer and employee contributions. The trust is an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974. One of the trust terms provides that upon approval by the trust, a trust member can establish a general policy to continue making contributions to the trust on behalf of a disabled employee for up to 180 days after the employee becomes disabled.

The defendant adopted this general policy providing that it would continue to make contributions for its disabled employees for 90 days regardless of whether the disability was work related or not. The applicant's monthly trust contribution was $20.00.

During the first three months of the applicant's temporary disability the employer made contributions to the trust in accordance with the general policy. The applicant sent monthly checks of $20.00 to the trust up to August 2000. The employer returned the August check to the applicant with a letter advising him that it provided medical coverage for disabled employees for 90 days only, and after that, the applicant could continue his health coverage under COBRA.

In September the applicant's attorney responded to the employer that any termination of the applicant's health coverage while he was temporarily disabled would violate L.C. §132a. The attorney enclosed a check for the applicant's September and October contributions.

The defendant did not comply with the attorney's request, and the applicant responded by filing a petition for increased benefits under L.C. §132a.

The petition was heard in June 2001, and in August the WCJ issued a findings and order in which he reasoned that the employer's policy of continuing health coverage for only 90 days applied equally to all employees whether the disability was industrial or not, and therefore the policy was not discriminatory.

The applicant filed a petition for reconsideration arguing that L.C. §132a is violated when an employer terminates an industrially injured employee's group medical coverage while the employee is temporarily disabled, and that ERISA does not preempt L.C.§132a claims because it does not permit an employer to avoid its liability under state worker's compensation laws.

Because of the importance of the ERISA preemption issue and the need for uniformity of decision, the Appeals Board issued this en banc decision.

The Appeals Board reviewed ERISA which contains an express preemption clause in Title 29 United States Code §1144(a). The clause states that ERISA shall supercede any and all State laws insofar as they relate to any employee benefit plan. The objective of Congress was to establish the regulation of employee welfare benefit plans as an exclusively federal matter.

The Appeals Board found the case of *Scotti v. Los Robles Regional Center* (2000) 117 F. Supp. 2d982 to be squarely on point. The court there found that the remedies afforded by L.C.§132a could not be effectuated without requiring the employer to violate or amend the provisions of the ERISA plan. ERISA preempts state laws that target conduct that ERISA permits.

The Appeals Board concluded that where an injured employee's claim is premised on the employer's termination of group health plan benefits to the employee pursuant to the terms of an ERISA plan, the claim "relates to" the ERISA plan and is therefore preempted by ERISA. The Board ordered that the applicant's petition for reconsideration be dismissed.

8. *Rivera v. Tower Staffing and Crump v. Los Angeles Unified School District* (2002) (WCAB En Banc) 67 CCC 1473.

In an En Banc decision in two cases, the Board held that the L. C. § 4650(d) penalty provision for delayed periodic payments does not apply to delayed lump sum payments of commutations or compromise and releases.

In *Rivera*, applicant had a stipulated award of 75% permanent partial disability, and with the stipulations, sought commutation of both the remaining weeks of the award and the following life pension. The WCJ approved the stipulations and issued a conditional order of commutation. There was no objection, and applicant filed a Declaration of Readiness seeking L. C. §§ 5814 and 4650(d) penalties for alleged underpayment of the commutation. Twenty-two days after the award the defendant paid $18,088.62 in

attorneys fees (including $88.62 in interest) and $22.13 to applicant. The award was for $72,295.09 in permanent partial disability followed by a $51.75 per week life pension. The WCJ indicated in his report and recommendation that the sum due on commutation was $109,659.08. Prior to determination in the penalty proceedings, State Compensation Insurance Fund paid the balance due on the commutation plus $10,424.84 as L. C. §4650(d) penalty.

The WCJ awarded two L. C. § 5814 penalties, one for unreasonable delay in payment of the commutation, and one for unreasonable underpayment of the $10,965.01 in L. C. §4650(d) penalty. State Compensation Insurance Fund sought reconsideration contending that only one penalty should have been awarded.

In *Crump* the employee was found to have sustained fatal injuries in March 1999. By August, 1999, appellate review sought by defendant had been denied. The parties thereafter settled the dependent's benefit entitlement for $140,000.00. Payment of the Compromise and Release proceeds was unreasonably delayed, and applicant sought penalties.

After a hearing the WCJ awarded two L. C. § 5814 penalties on May 15, 2001, one for delay of payment of the compromise and release proceeds, and one for failure to pay interest on the C&R from date of award to date of payment. Both parties sought reconsideration. Defendant contended that only one penalty was warranted by the delay; applicant contending that there should also have been a L. C. § 4650(d) penalty. The Board struck one of the L. C. § 5814 penalties, and remanded the matter for determination of defendant's liability for penalty under L. C. § 4650(d).

On remand, the matter was submitted for decision, and the WCJ found that while L. C. §4650(d) applies to dependency benefits, applicant had waived the penalty by failure to raise it prior to the filing of the Petition for Reconsideration from the May 15, 2001, Findings and Award. Applicant sought reconsideration contending L. C. § 4650 (d) was supposed to be self-executing.

The Appeals Board granted reconsideration in both cases, and in an En Banc decision held that L. C. § 4650(d) imposes a strict liability penalty on the sum(s) of periodic payments of disability indemnity not timely made by defendants. The Board found that "the proceeds of commutation or a settlement agreement are no longer periodic, installment indemnity payments as described in section 4650…" Defendant in *Rivera* was not liable for L. C. § 4650(d) increase in dependency benefits because the compromise and release ended defendant's liability for periodic payments of benefits, and the lump sum payment was not subject to L. C. § 4650(d). Defendant in *Crump* was not subject to L. C. §4650(d) increase in permanent disability and life pension payments because the order of commutation ended defendant's liability for periodic payments of indemnity.

XXIX Attorneys fees

McDonnell & Weaver v. W.C.A.B. (Morgan) (2002) (writ denied) 67 CCC 477.

McDonnell & Weaver filed three Applications for Adjudication of Claim, and were substituted out by Donald Galine. McDonnell and Weaver filed a lien for attorney fees. About ten weeks later, a Third Party Compromise and Release was filed settling the claims for $810,000, payable $588,626.30 to applicant, $60,000 to employer. No provision was made for fees for applicant's attorneys or lien claimant McDonnell and Weaver. Order Approving Third Party Compromise and Release issued, and was served on McDonnell and Weaver on August 25, 2000. On November 30, 2000, McDonnell and Weaver filed a petition to fix fees. After conference hearing the matter was submitted on the issue of jurisdiction of the board to consider McDonnell and Weaver's petition to fix fees. The WCJ concluded that when McDonnell and Weaver were served with the Order Approving Third Party Compromise and Release, which did not address their lien, and failed to file a timely Petition for Reconsideration, the jurisdiction of the Board to award a fee expired. The WCAB denied reconsideration, and the Court denied lien claimant's petition for writ of review.

XXX Civil Actions

1. Bakshi v. State Compensation Insurance Fund (2002) 67 CCC 1126 (unpublished).

Applicant filed a workers' compensation claim against his employer, the California Youth Authority (CYA). In defending the claim, SCIF obtained medical reports filed by applicant in a claim against a prior employer. The WCAB was apparently convinced that applicant's problems were caused by his earlier employment and not at CYA.

Applicant filed a civil suit against SCIF and its attorney, accusing them of fraud, defamation, fabrication of evidence, violation of due process, unfair business practice practices and intentional infliction of emotional distress. He alleged that the defendants had used medical reports filed on his behalf in the prior claim knowing that they were written by "scam doctors" who had been sued by SCIF. Defendants demurred generally and also specifically on the ground that the claims were barred by collateral estoppel and Civil Code §47(b).

Before the hearing on the demurrers, applicant requested dismissal of SCIF, later arguing that he had intended to dismiss it only from the amended complaint. The judge ruled that applicant had released SCIF from the entire action, and then sustained the attorney's demurrer, without leave to amend, on the ground that the complaint stated no cause of action and was barred by collateral estoppel. The attorney's conduct was also privileged under §47(b), and she was immune from liability under the Government Code as a public employee. Applicant appealed.

The Court of Appeal upheld the decision. Civil Code §47(b) creates a privilege for any communication made in judicial or quasi-judicial proceedings by litigants if made to achieve the objects of the litigation and if related to it. The privilege is absolute and applies to workers' compensation cases.

The court recounted the numerous allegations and noted that all the communications were made in furtherance of the litigation. Thus, all the communications fall within the privilege.

Applicant had also alleged that there was negligent review and investigation of false medical reports. The court noted that those were all alleged against SCIF, and that SCIF had been dismissed.

The judgment was affirmed, and SCIF and its attorney were awarded their costs.

2. Fremont Industrial Indemnity Company v. Laughlin, Falbo, Levy & Moresi (2002) (not published) 67 CCC 278.

In February 1997 the defense firm Laughlin, Falbo et al. (LFLM) contracted with Industrial Indemnity Company. to represent them in workers' compensation litigation. In August, 1997, Fremont acquired the workers' compensation business of Industrial Indemnity, and LFLM began representing Fremont in some cases pursuant to the contract between Industrial and LFLM, including the case of *Clark* who had filed for penalties against Fremont for paying him in financial instruments that were not immediately negotiable.

On 10/8/98 a LFLM attorney appeared at a conference and signed stipulations and issues which listed an array of penalties as issues for trial. The trial was held on 12/15/98 at which time another attorney appeared from LFLM on behalf of Fremont. The attorney appearing on behalf of Fremont argued that the trial should not proceed, claiming there was insufficient notice of penalty, but the trial judge disagreed and proceeded with the hearing. After trial, a claims vice president from Fremont opined in correspondence to LFLM that they had malpracticed at trial and that LFLM would be held accountable for any penalties awarded.

On 3/18/99 the WCALJ issued a decision awarding penalties pursuant to Labor Code §§4651, 5800, and 5814 and awarded an attorney fee of 30 percent of benefits awarded, but the ruling did not state the number or amount of penalties. The defendant sought reconsideration. On 7/14/99 the WCAB denied LFLM's reconsideration petition as untimely. On 10/1/99, the DCA denied LFLM's writ petition, upholding the WCAB's decision to dismiss the petition for reconsideration as untimely.

On 10/12/99, Fremont signed a substitution of attorney form and faxed it to LFLM with instructions to sign and return it the same day. The demand was accommodated. LFLM's file was shipped to new counsel no later than 10/19/99 after which LFLM took no further action on behalf of Fremont on the *Clark* matter. On 10/21/99 Fremont memorialized an agreement to settle penalties with the applicant by sending Clark a confirmatory letter. The substitution of counsel for Fremont was filed, and approval of the settlement occurred at a hearing on 11/15/99. Also on 10/21/99 Fremont put LFLM on notice of a malpractice claim and sought an agreement to toll the statute of limitations; an agreement that was never affirmed. Fremont sued LFLM for professional malpractice and breach of

contract on 10/31/00 leaving LFLM to request summary judgment claiming that Fremont did not file their claim within one year as required by statute.

The limitations statute requires the filing of a malpractice action one year from the discovery of the wrongful act or omission or four years from the wrongful act or omission which ever first occurs. This period can be tolled if the attorney continues to represent the plaintiff regarding the specific subject matter in which the wrongful act or omission occurred. Although the substitution of attorney whereby Fremont was no longer represented by LFLM was not filed until the hearing on 11/15/99, LFLM's representation objectively ended when LFLM's file was returned on 10/19/99, not the 11/15/99 hearing. It was further determined that the act of malpractice was known to Fremont before the settlement of penalties, for $775,000.00, was approved at the 11/15/99 hearing. Fremont was aware of potential malpractice as early as 12/15/98 and certainly after the 03/18/99 ruling. There being no timely filing of the malpractice claim, and no real factual dispute, LFLM's motion for summary judgment was granted.

3. *Lopez v. C.G.M. Development, Inc*. (2002) 67 CCC 1023 (Certified for Publication).

C.G. M. Development, Inc. (CGM), a property owner, entered into a contract with Dekkon Development, Inc. (Dekkon) to develop commercial property. Dekkon hired a subcontractor L&E Builders (L&E) to frame a roof. L&E 's work complied with the architectural plans drafted by architect John Cataldo, with Dekkon to supply all materials, except nails. An employee of Dekkon was responsible for scheduling subcontractors and holding weekly safety meetings. An employee of L&E supervised employees working on the roof. Dekkon demanded that L&E employees wear safety equipment, especially harnesses, prompting L&E to require all workers to leave the roof until the proper safety equipment could be obtained. L&E was not insured for workers' compensation, but was a licensed contractor. At no time did CGM supervise L&E employees or tell them how to do their jobs.

Lopez, an employee of L&E, was not wearing a harness or other safety equipment when he fell 30 feet onto a concrete floor, suffering serious injuries. Lopez sued CGM on a negligence theory, alleging that it had maintained dangerous working conditions at the jobsite and for not providing Lopez with safety equipment. CGM filed a motion for summary judgment which was granted by the trial court. Lopez filed an Appeal.

On appeal the court was left to decide whether Lopez could recover damages from CGM based on the peculiar risk doctrine where a person who hires an independent contractor to perform work that is inherently dangerous can be held liable for tort damages when the contractor 's negligent performance of the work causes injuries to others.

Citing the analysis of the peculiar risk doctrine in *Privette v. Superior Court* (1993) 58 CCC 420, the court determined that the principal who hires an independent contractor should be subject to no greater liability than its independent contractor against whose exposure for injury to an employee is limited to providing workers compensation insurance. Allowing the injured worker to sue the principle who hired the contractor to be sued on a peculiar risk theory would give the worker an unwarranted windfall not available to other injured workers. This result might be different where the property

owner and hirer of the contractor retains control over the workplace and negligently undertakes that task proximately causing an injury; a condition that clearly did not occur here.

Applicant argued that previous cases are distinguishable since this subcontractor, L&E, did not have the requisite workers' compensation insurance. Applying the principles of the exclusive remedy doctrine, the court rejected this theory and determined that the property owner is entitled to the same protection that the exclusive remedy provides an insured subcontractor. When the subcontractor is illegally uninsured, that contractor can be held liable for civil damages, but the entity that hired that subcontractor is still entitled to the provisions of the exclusive remedy. Normally the consideration for the contract includes the cost of the contractor's workers' compensation insurance. Even though that could not have been the case here, the court used the reasoning in *Privette*, which states that the principal who hires the contractor should be at no greater risk than the contractor; the principal continues to enjoy the benefits of exclusivity. The court imposed no duty on CGM to ascertain whether the contractors or subcontractors working in its interest have workers' compensation insurance; it is reasonable to assume that a contractor will have workers' compensation insurance and the cost of that insurance will be passed on as part of the price of the contract.

The court similarly dispensed with Applicant's retained control argument since it was demonstrated that the CGM employee occasionally visited the job site, but did not attempt to exercise any control over the workers and did not tell any workers how to do their job. Applicant's accident could not have been caused by an act or omission of CGM.

Disclaimer

This case law summary is designed to present a summary of current cases. The authors have attempted to present an accurate summary of each case. However, the summaries are the interpretations of the authors, and cases are often open to more than one interpretation. Furthermore, the reader should read each case for himself as the summaries may contain errors, and cases are subject to being reversed or revised by the courts after publication of the case law summary. It is recommended that parties review the actual cases before citing them.

The opinions and analyses given in this case law summary are those of the authors and are not to be considered those of the Department of Industrial Relations or the Workers' Compensation Appeals Board.