WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

THE ROMANO TRUST, on behalf of CHARLES ROMANO, deceased, ***Applicant,*** **vs.** **THE KROGER CO. dba RALPH'S GROCERY CO., permissibly self-insured, administered by SEDGWICK CMS,** ***Defendants.***	**Case No. ADJ1372133 (VNO 0488219)** **OPINION AND DECISION AFTER RECONSIDERATION**

We previously granted reconsideration to further study the factual and legal issues in this case. This is our Opinion and Decision After Reconsideration.

Defendant seeks reconsideration of the February 13, 2012 Supplemental Findings and Award. In that decision, the workers' compensation administrative law judge (WCJ) addressed defendant's repeated efforts to avoid or postpone its statutory duty to provide medical care, egregious behavior which increased the suffering of a horrifically ill individual.

The WCJ found that applicant, Charles Romano, while employed as a stocker for Ralph's Grocery Company on December 20, 2003, sustained an industrial injury to his left shoulder and cervical spine "with subsequently industrially-related staph infection resulting in a compensable consequence injury to the neck, cardiovascular system, pulmonary system, thoracic spine (with resulting paralysis) and as further compensable consequence injury to urinary/fecal incontinence, renal failure, psyche, and vision (bilateral retinal hemorrhages)."[1] Among other things, the WCJ also held that defendant unreasonably delayed medical care in 11 separate instances, imposing for each one the maximum penalty under Labor

[1] Tragically, Mr. Romano's industrial injury ultimately led to his death. However, an inter vivos application was filed on his behalf and, for convenience, we will refer to Mr. Romano as applicant rather than decedent.

Code Section 5814: 25% of the delayed medical benefit, not to exceed $10,000.[2] The WCJ also held that applicant was entitled to attorney's fees under section 5814.5 at the rate of $350 per hour, but the reasonable amount of the fee was deferred. The WCJ did not permit defendant to withdraw from a January 15, 2009 trial stipulation in which the parties agreed to present trial testimony in the form of depositions.

Defendant contends that no penalties for delay can be imposed because (1) applicant is now deceased; (2) the penalty issues were not heard within two years of the date that payment of compensation was due; (3) the incidents in question were not separate and distinct acts of misconduct subject to multiple penalties; (4) the WCJ did not set forth sufficient reasons for the imposition of each penalty; and (5) there was no unreasonable delay. Defendant further contends that, even if any penalties are warranted, applicant's attorneys' fees are excessive. Defendant also requests that the parties' stipulation regarding deposition testimony be set aside.

We have considered the Petition for Reconsideration and applicant's Answer. The parties have shown good cause why they should be allowed to exceed the page limit, so we grant both of their requests to do so. (Cal. Code Regs., tit. 8, §§ 10845(a), 10232(1).) The WCJ prepared a Report of Workers' Compensation Judge on Petition for Reconsideration (Report). For the reasons stated in the Report, which we hereby adopt and incorporate, and for the reasons discussed below, we will affirm the February 13, 2012 Supplemental Findings and Award, except that we will amend Finding No. 8 to clarify that the billing for St. John's Hospital is not included in the penalty for delayed reimbursement of the Medi-Cal lien.

We have rarely encountered a case in which a defendant has exhibited such blithe disregard for its legal and ethical obligation to provide medical care to a critically injured worker. Sedgwick CMS, acting as claims administer for The Kroger Company/Ralph's Grocery Company, demonstrated a callous indifference to the catastrophic consequences of its delays, inaction, and outright neglect. In light of defendant's repeated, unreasonable delays and denials, and its willingness to ignore a 2006 Finding and

[2] All further statutory references are to the Labor Code, unless stated otherwise.

Award issued by the Workers' Compensation Appeals Board, we will refer this case to the Audit Unit of the Division of Workers' Compensation (DWC). (See Lab. Code, § 129(b)(3); see also Cal. Code Regs., tit. 8, §§ 10100.2(o), 10106(b), 10106.1(c)(3).)[3]

I.

Although a thorough description of the facts may be found in the WCJ's Report, we will very briefly summarize them here for the purpose of clarity. (Report, pp. 3-45.)

Applicant Charles Romano sustained an admitted industrial injury to his left shoulder on December 20, 2003 and underwent surgery on August 29, 2005.

As a result of his surgery, applicant contracted methicillin-resistant staphylococcus aureus (the antibiotic-resistant staph infection known as MRSA), resulting in catastrophic, multi-system injury including renal failure, pulmonary failure, and paralysis from C8 down. Applicant was hospitalized at Ventura County Medical Center, which was paid for by Medi-Cal because defendant refused to authorize treatment. After his discharge, applicant self-procured treatment at County Villa Oxnard Manor, a facility unequipped to deal with his complex injuries; he was then hospitalized at St. John's Regional Medical Center after a visiting friend discovered that applicant's catheter bag was full of blood. (See Report, pp. 3-4.)

On October 25, 2006, a prior WCJ issued an Amended Findings and Award holding, among other things, that applicant sustained an industrial injury to the "left shoulder and cervical spine with subsequently industrially related staph infection resulting in a compensable consequence injury to his neck, cardiovascular system, pulmonary system, thoracic spine with resulting paralysis." Applicant was awarded further medical treatment, and defendant was ordered to pay or adjust all reasonable medical and medical-legal liens.[4] Defendant did not comply, failing to pay medical costs incurred in treating applicant's industrial injury, including the hospital care previously provided by St. John's Regional

---

[3] The Audit Unit not only audits insurers, but also self-insured employers and third-party administrators. (Lab. Code, § 129(a).)

[4] Defendant sought reconsideration of this decision, but the Appeals Board denied its petition. Defendant's subsequent petition for writ was summarily denied on June 19, 2007. (*Ralph's Grocery Co. v. Workers' Comp. Appeals Bd.* (*Romano*) 72 Cal.Comp.Cases 1028 (writ den.).)

Medical Center and Ventura County Medical Center. (See Report, pp. 4-5; 29-31 [no payment made until July 23, 2008].)

After several hospitalizations, applicant was eventually transferred to Care Meridian, a facility with only a single doctor, despite applicant's complicated and potentially deadly multi-system medical conditions. (See Report, pp. 6-9.) Throughout this time, despite the October 2006 award of further medical care, defendant delayed providing some medical services and refused to authorize others. Several times, defendant's claims adjuster, Theresa McDivitt, denied treatment (or withheld authorization) without consulting with a medical professional and without referring the request for treatment to utilization review. (See Report pp. 22-25 [denial of Bi-Pap machine], 26-28 [failure to authorize hospitalization], 31-32 [failure to authorize venous/Doppler studies and psychiatric consult].) Authorization of other treatment was delayed. (See Report, p. 20-23 [four month delay of provision of wheelchair]; 35-38 [delay in appointment of nurse case manager].) Payment for various medical services was delayed or never made at all. (Report p. 28-29 [X-rays and CT scans], 39-40 [hospitalization], 40-41 [ambulance], see also 41-43 [guardian ad litem expenses].) Defendant continued to deny or delay care through the end of applicant's life, failing to authorize his final hospitalization at Community Memorial Hospital, where he died on May 2, 2008 from cardiorespiratory arrest, respiratory failure and pneumonia brought on by his industrial MRSA infection and related medical conditions. (Report, pp. 2-9, 26-28.)

In the February 13, 2012 Supplemental Findings and Award, the WCJ found that defendant had unreasonably delayed or denied medical treatment in 11 separate instances and awarded penalties accordingly. Defendant then filed the present petition.

II.

Section 4600(a) provides: "Medical ... treatment ... that is reasonably required to cure or relieve the injured worker from the effects of his or her injury *shall be provided by the employer* [emphasis added]." Of course, "shall" denotes a mandatory duty. (Lab. Code, § 15.) Therefore, in *Braewood Convalescent Hosp. v. Workers' Comp. Appeals Bd.* (*Bolton*) (1983) 34 Cal.3d 159, 165 [48 Cal.Comp.Cases 566], the Supreme Court said: "Section 4600 requires more than a passive willingness on the part of the employer to respond to a demand or request for medical aid. [Citations.] This section

requires *some degree of active effort to bring to the injured employee the necessary relief* [emphasis added]."

Over the years, the Courts of Appeal have made similar statements. For example, in *Ramirez v. Workers' Comp. Appeals Bd.* (1970) 10 Cal.App.3d 227, 234 [35 Cal.Comp.Cases 383], the Court said:

> "Upon notice or knowledge of a claimed industrial injury an employer has both the right and *duty to investigate the facts* in order to determine his liability for workmen's compensation, but he must act with expedition in order to comply with the statutory provisions for the payment of compensation which require that he *take the initiative in providing benefits*. He must seasonably offer to an industrially injured employee that medical, surgical or hospital care which is reasonably required to cure or relieve from the effects of the industrial injury...[emphasis added]." (Accord, *Aliano v. Workers' Comp. Appeals Bd.* (1979) 100 Cal.App.3d 341, 366-367 [44 Cal.Comp.Cases 1156, 1172]; *Dorman v. Workers' Comp. Appeals Bd.* (1978) 78 Cal.App.3d 1009, 1020 [43 Cal.Comp.Cases 302, 308].)

Similarly, in *United States Cas. Co. v. Industrial Acc. Com.* (*Moynahan*) (1954) 122 Cal.App.2d 427, 435 [19 Cal.Comp.Cases 8], the Court said:

> "Section 4600 of the Labor Code places the responsibility for medical expenses upon the employer when he has knowledge of the injury. ... [¶¶] The duty imposed upon an employer who has notice of an injury to an employee is *not ... the passive one of reimbursement but the active one of offering aid in advance and of making whatever investigation is necessary* to determine the extent of his obligation and the needs of the employee [emphasis added]."[5]

In addition to these judicially announced obligations to do more than passively sit by, defendants also have a regulatory duty to conduct a reasonable and good faith investigation to determine whether benefits are due. Specifically, Administrative Director Rule 10109 provides, in relevant part:

> "(a) ... [A] claims administrator must conduct a reasonable and timely investigation upon receiving notice or knowledge of an injury or claim for a workers' compensation benefit.

[5] See also, e.g., *Bergenstal v. Workers' Comp. Appeals Bd.* (1996) 45 Cal.App.4th 1272, 1277 [61 Cal.Comp.Cases 437] [" '[i]t is the duty of an employer ... *to take the initiative* in furnishing [medical treatment]' [emphasis added]" [quoting from *Deauville v. Hall* (1961) 188 Cal.App.2d 535, 540 [26 Cal.Comp.Cases 44])]; *Henson v. Workmen's Comp. Appeals Bd.* (1972) 27 Cal.App.3d 452, 457 [37 Cal.Comp.Cases 564] ["[a]n employer has the *affirmative statutory duty to provide medical ... treatment* [emphasis added]."].

"(b) A reasonable investigation must attempt to obtain the information needed to determine and timely provide each benefit, if any, which may be due the employee.

"(1) The administrator may not restrict its investigation to preparing objections or defenses to a claim, but must fully and fairly gather the pertinent information, whether that information requires or excuses benefit payment. ... The claimant's burden of proof before the Appeal Board does not excuse the administrator's duty to investigate the claim.

"(2) The claims administrator may not restrict its investigation to the specific benefit claimed if the nature of the claim suggests that other benefits might also be due.

"(c) The duty to investigate requires further investigation if the claims administrator receives later information, not covered in an earlier investigation, which might affect benefits due.

***

"(e) Insurers, self-insured employers and third-party administrators shall deal fairly and in good faith with all claimants, including lien claimants."

(Cal. Code Regs., tit. 8, § 10109.)

If a defendant unreasonably breaches its affirmative duty to provide timely medical care, penalties are available under section 5814.[6] That statute provides: "When payment of compensation has been unreasonably delayed or refused, either prior to or subsequent to the issuance of an award, the amount of the payment unreasonably delayed or refused shall be increased up to 25 percent or up to ten thousand dollars ($10,000), whichever is less." (Lab. Code, § 5814(a).) "Compensation embraces every benefit or payment to which an injured employee is entitled, including reasonably required medical, surgical, and hospital treatment." (*Ramirez, supra,* 10 Cal.App.3d at p. 234.) Once an employer's delay in paying compensation is shown, the burden shifts to the employer to show good cause for the delay. (*Id.* at p. 235.)

---

[6] Other remedies are also available. A defendant's bad-faith or frivolous delay in providing or failure to provide medical treatment may result in a sanction for each bad-faith or frivolous act or failure to act (Lab. Code, § 5813; Cal. Code Regs., tit. 8, § 10561), and a defendant's breach of its duties under Administrative Director Rule 10109 may result in audit penalties. (Cal. Code Regs., tit. 8, §§ 10111.1(c)(6) & (d)(1), 10111.2(b)(1) & (2).) The issue of sanctions is not presently before us, though we expressly reserve jurisdiction over that issue at the trial level. It will be up to the Audit Unit to consider the possibility of audit penalties.

In determining whether compensation has been "unreasonably delayed" within the meaning of section 5814, "the only satisfactory excuse for delay in payment of disability benefits, whether prior to or subsequent to an award, is genuine doubt from a medical or legal standpoint as to liability for benefits." (*Kerley v. Workmen's Comp. Appeals Bd.* (1971) 4 Cal.3d 223, 230 [36 Cal.Comp.Cases 152]; accord, *State Comp. Ins. Fund v. Workers' Comp. Appeals Bd.* (*Stuart*) (1998) 18 Cal.4th 1209, 1220 [63 Cal.Comp.Cases 916].) "[T]he burden is on the employer or [its] carrier to present substantial evidence upon which a finding of such doubt may be based." (*Kerley, supra,* at p. 230.)

The WCJ's Report contains a detailed explanation for each finding of unreasonable delay (Report, pp. 20-42), so we will not address every one individually.[7] Some of defendant's arguments about specific penalties, however, do warrant additional discussion.

a) The unreasonable delay in providing a wheelchair with tilt.

This issue is specifically addressed by the WCJ's Report at pages 20 to 24.

As admitted by defendant's claims adjuster, Ms. McDivitt, utilization review certified the provision of a motorized wheelchair with tilt on April 26, 2007 (Exh. 52), but the wheelchair was not delivered until four months later. (Exh. 109 [March 3, 2009 Deposition of Theresa McDivitt], p. 74:17-75:13 [stating wheelchair delivered on August 27, 2007]; Exh. 92B [email from Ms. McDivitt stating that wheelchair was delivered August 24, 2007].) Applicant, who was paralyzed, required a wheelchair with tilt in order to gain some mobility without suffering from ulcers. (Exh. 111 [March 2, 2010 deposition of

/ / /

---

[7] Each of the following contentions is thoroughly addressed in the following pages of the WCJ's Report: (1) regarding defendant's unreasonable delay in paying the bill of Community Imaging (see Petition, at 23:20-24), see the WCJ's Report at pages 28 through 29; (2) regarding defendant's unreasonable delay in the provision of venous/Doppler studies and psychiatric consultation (Petition, at 25:6-26:4), see the WCJ's Report at pages 29 through 32; (3) regarding defendant's unreasonable delay in reimbursement for a wheelchair accessible van (Petition, at 26:5-26:23), see the WCJ's Report at pages 32 through 35; (4) regarding defendant's unreasonable delay in the appointment of a nurse case manager upon applicant's discharge from Northridge Hospital in September 2007 (Petition, at 26:24-28:2), see the WCJ's Report at pages 35 through 38; (5) regarding defendant's unreasonable delay in paying Gold Coast Ambulance's transportation expense (Petition, at 28:14-29:7), see the WCJ's Report at pages 40 through 41; and (6) regarding defendant's unreasonable delay in paying applicant's Guardian Ad Litem for her time and expense in transporting applicant to medical appointments and in remaining with him there (Petition, at 29:8-30:2), see the WCJ's Report at pages 41 through 43.

Susan Crane, RN], p. 20:14-21:5; see Exh. 45 [December 6, 2012 deposition of Dr. Joel S. Rosen] p. 25:1-26:19.)

Defendant contends, without any citation to the record, that this delay was reasonable because applicant "had the availability of a wheelchair" at Northridge Hospital, where he was hospitalized at the time. (Petition, p. 19:17-19:18.) That contention was fully rebutted by the deposition testimony of Susan Crane, RN, applicant's nurse case manager, that there was no wheelchair available at Northridge that would have been suitable. (Exh. 111, p. 46:17-46:20.) Defendant is advised that "[e]very petition for reconsideration...shall fairly state *all* of the material evidence relative to the point or points at issue [emphasis added]." (Cal. Code Regs., tit. 8, § 10842(a).) Failure to comply is a basis for denying a petition and may be subject to sanction. (*Ibid.*; Lab. Code, § 5813, Cal. Code Regs., tit. 8, § 10561(b).)

b) The unreasonable delay in providing a BiPAP machine.

This issue is specifically addressed by the WCJ's Report at pages 24 to 26.[8]

Ms. Crane and Dr. Joel S. Rosen, one of applicant's treating physicians, testified during deposition that applicant's paralysis was affecting the muscles that control breathing, a potentially fatal condition. (Exh. I11, pp. 31:18-33:9; Exh. 45, pp. 15:20-16:2; see also Exh. 90A [August 31, 2007 letter from Dr. Rosen to applicant's counsel stating that Bi-PAP had been denied and that applicant had "actually stop[ped] breathing for periods of time..."].) Ms. McDivitt denied a request for a BiPAP machine to relieve applicant's sleep apnea; she testified that she could not recall referring that prescription to utilization review, and there is nothing in the record suggesting that she did so. (Exh. 109 [March 3, 2009 deposition of Theresa McDivitt], pp. 36:11-25.) After initially testifying that she "believe[d]" she had called or written to a medical provider about the BiPAP, she later admitted that she had denied the claim based on her own lay evaluation of the medical records, without contacting applicant's physician. (*Id.* at pp. 36:11-25, 38:6-41-22.)

/ / /

[8] We note the WCJ's statement at page 26 of his Report that "there is substantial evidence to support the findings made [that] the defendant unreasonably delayed medical treatment in the form of [a] motorized wheelchair with tilt" is clerical error. It should read "there is substantial evidence to support the findings made that the defendant unreasonably delayed medical treatment in the form of a Bi-PAP machine."

Defendant's assertion that it had genuine medical and legal doubt about its obligation to provide the machine because it could not "have guessed that the sleep apnea was caused or aggravated by the Applicant's industrial injury" and was "entitled to investigate before blindly issuing medical treatment *for a non-industrial condition*" is utterly without merit. (Petition, pp. 22:3-22:12 [emphasis added].) The October 25, 2006 Amended Findings and Award established that shoulder surgery performed to treat applicant's admitted December 20, 2003 industrial injury had caused a MRSA infection that resulted in "paralysis" and injury to the "pulmonary system" *as a compensable consequence of the original injury.* Even assuming that applicant's sleep apnea was pre-existing, the WCJ's Report correctly observed that a defendant is liable to treat even an entirely non-industrial condition if such treatment is reasonably required in order to cure or relieve the effects of an industrial injury. (*Bolton, supra*, 34 Cal.3d at pp. 165-166 [employee with non-industrial obesity entitled to weight loss in order to facilitate his recovery from back injury]; see also *Granado v. Workmen's Comp. Appeals Bd.* (1968) 69 Cal.2d 399, 405-406 [33 Cal.Comp.Cases 647, 652] ["treatment for nonindustrial conditions may be required of the employer where it becomes essential in curing or relieving from the effects of the industrial injury itself"].) The evidence unequivocally established that applicant needed the BiPAP to cure or relieve the effects of the breathing problems resulting from his industrially-caused paralysis and pulmonary condition.

c) The unreasonable delay in authorizing treatment and paying for treatment at Community Memorial Hospital.

This issue is specifically addressed by the WCJ's Report at pages 26 to 28.

An emergency room report states that applicant was admitted to Community Medical Hospital on April 24, 2008 for a potential congestive heart failure. (Exh. 102.) In other words, he was admitted for the MRSA-related pulmonary and cardiac condition which a WCJ found to be industrial in October 2006. Ms. McDivitt testified that she did not authorize this hospitalization because "they didn't know what was wrong with him." (Exh. 109A, p. 25:7-17.) Defendant asserts that it did not unreasonably delay authorizing and paying for the hospitalization at Community Memorial Hospital because its claims adjuster "had no clue as to why the Applicant was being hospitalized." (Petition, pp. 7:2-7:4, 23:14.)

As discussed above, section 4600(a) imposes a mandatory duty to timely provide reasonably required medical treatment. The Labor Code does not permit a defendant to bury its head in the sand in order to dodge its obligations. (See *Braewood Convalescent Hosp.* (*Bolton*), *supra*, 34 Cal.3d at p. 165; *Ramirez, supra*, 10 Cal.App.3d at p. 234; *Aliano, supra*, 100 Cal.App.3d at pp. 366-367; *Dorman, supra*, 78 Cal.App.3d at p. 1020; *United States Cas. Co.* (*Moynahan*), *supra*, 122 Cal.App.2d at p. 435; Cal. Code Regs., tit. 8, § 10109.) Ms. McDivitt studiously avoided information that might lead to the provision of benefits, a tactic that may have saved her employer some money in the short run—at great cost to Mr. Romano—but which clearly violated the demands of section 4600.

Applicant was admitted to the hospital in April 2008 because he was profoundly ill with serious, life-threatening medical conditions that were all related to his industrial injury. (See, e.g., Exh. 100 [April 24, 2008 report of Dr.Tara M. Snow]; Exh. 101 [June 9, 2008 discharge summary by Dr. Diane Li]; Exhibit 102 [April 24, 2008 report of Dr. Mark Reynoso]; Exh. 103, [April 28, 2008 report of Dr. Thomas Brugman]; Exh. 106 [April 30, 2008 progress note of Dr. Robert Feiss].) These conditions had been found compensable a year and a half earlier, in the WCJ's October 2006 award. Defendant could have easily identified these conditions as work-related with a simple inquiry.

Defendant's Petition for Reconsideration cites no evidence in the record indicating that it made any serious, timely investigation into applicant's April 2008 hospitalization. To the contrary, defendant's petition merely cites to evidence that, after being notified that "the Applicant was on his way to the hospital with an unknown illness," its claims adjuster had *one conversation* with Community Memorial Hospital. (Petition, at 6:25-6:28; see Exh. 109, p. 25:7-27:12.) This breach of defendant's affirmative statutory and regulatory duties exemplifies defendant's efforts to "evade liability through a see-no-evil, hear-no-evil, passive approach to claims administration in a catastrophic, life-and-death case," as aptly described in applicant's Answer to the Petition for Reconsideration. (Answer, p. 22:16-22:19.)

d) Unreasonable delays in reimbursing the Department of Health Services (Medi-Cal).

This issue is specifically addressed by the WCJ's Report at pages 29 through 32.

The October 25, 2006 Amended Findings and Award ordered defendant to pay or adjust all reasonable industrial medical expenses *and* found that applicant was in need of further medical treatment.

Therefore, both pre- and post-award medical treatment was covered by the award. Medi-Cal submitted liens of $7,807.85 and $275,439.14 for various medical services provided to applicant from November 2005 through February 2007, with the majority of the services being rendered by Ventura County Medical Center, St. John's Regional Medical Center, Evergreen Pharmaceutical, and Country Villa Oxnard. (Exh. 55; Exh. 57; Exh. 58-B.) It is undisputed that defendant never directly paid these medical providers for treatment that occured either before or after the October 25, 2006 award.

Defendant's petition does not assert that it had a genuine doubt from a medical or legal standpoint as to its liability for these bills. Instead, defendant argues that "[g]iven the fact that treatment had already been provided and the sole issue was reimbursement [to Medi-Cal] for payments already made, there can be no finding of unreasonable delay with regard to the underlying treatment." (Petition, at 24:26-24:28.) However, a defendant's unreasonable failure to provide medical treatment is not excused by a State agency's payments for the treatment on a non-industrial basis. (Cf. *Ramirez, supra*, 10 Cal.App.3d 227 [Employment Development Department's payment of unemployment compensation disability benefits did not excuse defendant's failure to pay temporary disability indemnity].) Accordingly, it is immaterial whether or not the defendant made prompt payments to Medi-Cal after receiving its liens: the only question is whether defendant should have timely paid the treatment covered by the Medi-Cal liens in the first place.

Defendant also argues that "it would be improper to pay any penalty to applicant as any penalty, if found, would be owed to [Medi-Cal]." (Petition, p. 25:3-5].) However, section 5814 penalties are not payable to a lien claimant; they are payable only to the injured employee. (*Vogh v. Workmen's Comp. Appeals Bd.* (1964) 264 Cal.App.2d 724, 728 [33 Cal.Comp.Cases 491, 494] [overruled on other grounds in *Adams v. Workers' Comp. Appeals Bd.* (1976) 18 Cal.3d 226, 230 [41 Cal.Comp.Cases 680]]; *Minter v. Workers' Comp. Appeals Bd.* (1996) 61 Cal.Comp.Cases 1491 (writ den.).)[9]

/ / /

/ / /

[9] Defendant's argument that "it would be improper to pay any penalty to the Applicant as any penalty, if found, would be owed to Gold Coast Ambulance" fails for the same reason. (See Petition, p. 29:4-5.)

e) Unreasonable delay in reimbursing applicant for treatment at St. John's Regional Medical Center.

This issue is specifically addressed by the WCJ's Report at pages 38 through 40.

In his Report, the WCJ describes how defendant failed to pay for two hospitalizations at St. John's Regional Medical Center in 2006. (See Exh. 42 [Sep. 2, 2006 Discharge Summary]; Exh. 44 [Nov. 25, 2006 Discharge Summary]; Exh 68B [invoice]; 69A [Notice and Request for Lien].) However, defendant's unreasonable failure to pay for applicant's treatment at St. John's was part of the basis for the separate penalty, discussed above, relating to the Medi-Cal lien. It is improper for defendant to be penalized twice for the same delay. We will therefore amend Finding No. 8 of the Supplemental Findings and Award to exclude St. John's billings in determining the penalty for the delay in reimbursing Medi-Cal.

III.

As discussed above, applicant's injury eventually led to his death on May 2, 2008. Section 4700 states: "The death of an injured employee does not affect the liability of the employer under Articles 2 (commencing with Section 4600) and 3 (commencing with Section 4650) [of Chapter 2 of Part 2 of Division 4 of the Labor Code]." Defendant argues that section 5814 is in Chapter 6 of Part 4 of Division 4, thus penalties do not survive the death of the injured employee. (Petition, pp. 13-14.) However, "[s]ection 5814 penalties are part and parcel of the original compensation award." (*Mote v. Workers' Comp. Appeals Bd.* (1997) 56 Cal.App.4th 902, 911 [62 Cal.Comp.Cases 891].) The penalties are therefore a part of the original award of medical benefits due under section 4600 et seq. and are not affected by applicant's death. (Lab. Code, § 4700.)

Defendant also claims that the penalties are barred by section 5814(g), which provides: "Notwithstanding any other provision of law, no action may be brought to recover penalties that may be awarded under this section more than two years from the date the payment of compensation was due." However, this time limit is a statute of limitations and therefore an affirmative defense that may be waived. (*Abney v. Aera Energy* (2004) 69 Cal.Comp.Cases 1552, 1561 (Appeals Board en banc); cf. Lab. Code, § 5409 ["Failure to present such defense prior to the submission of the cause for decision is a

sufficient waiver."].) Defendant was required to raise the 5814(g) statute of limitations issue at the mandatory settlement conference and did not do so. (April 21, 2010 Mandatory Settlement Conference Statement; Lab. Code, § 5502(d)(3).) Although defendant mentioned 5814(g) in a July 30, 2010 Trial Brief, the statute of limitations was not raised as a defense during the December 20, 2010 trial. "The pleadings shall be deemed amended to conform to the stipulations and statement of issues agreed to by the parties on the record" (Cal. Code Regs., tit. 8, § 10492), and defendant agreed to a statement of issues that did not include the two-year limitation stated in 5814(g). (December 20, 2010 Minutes of Hearing and Summary of Evidence, p. 4.) Defendant therefore waived the purported section 5814(g) statute of limitations issue and we will not address it further.[10]

Defendant also contests the imposition of multiple penalties, which may be assessed only "when the unreasonable delay or refusal of [the] benefits [due] is attributable to separate and distinct acts by an employer or insurance carrier." (*Christian v. Workers' Comp. Appeals Bd.* (1997) 15 Cal.4th 505, 507 [62 Cal.Comp.Cases 576, 577]; see *Green v. Workers' Comp. Appeals Bd.* (2005) 127 Cal.App.4th 1426, 1443-1445 [70 Cal.Comp.Cases 294].) "A separate and distinct act of misconduct occur[s] where there was an unreasonable delay or refusal to pay after 'the same conduct had already been found ... to be unreasonable and a prior penalty imposed, or some analogous, legally significant event such as stipulation of liability by the carrier had intervened between the first act for which a penalty was imposed and the second." (*Ramirez v. Drive Financial Services* (2008) 73 Cal.Comp.Cases 1324, 1322 (Appeals Board en banc) [quoting *Christian, supra,* 15 Cal.4th at p. 511].)

Delays in providing different medical services may constitute separate and distinct acts of misconduct. (See *City of Los Angeles v. Workers' Comp. Appeals Bd.* (*Dalcour-Martinelli*) (1997) 62 Cal.Comp.Cases 1445 (writ den.); *St. Jude Hosp. v. Workers' Comp. Appeals Bd.* (*Limousin*) (1997) 62

---

[10] We observe that section 5814(g) merely requires that an action for penalties "be brought" within two years, not, as defendant contends, that it be heard or a declaration of readiness filed during that time period. (Petition, pp. 14-15.) An action for penalties is "brought" when a penalty petition is filed. (See *Abney, supra,* 69 Cal.Comp.Cases at p. 1561; *Pacific Steel Engineering v. Workers' Comp. Appeals Bd.* (*Finley*) (2005) 70 Cal.Comp.Cases 1365, 1368-1369 (writ den.).) Although the WCAB is not bound by the statutory rules of civil procedure (Lab. Code, § 5708), this interpretation is consistent with civil law, which provides: "An action is commenced... when the complaint is filed." (Code Civ. Proc., § 350; see also Code Civ. Proc., § 411.10 ["A civil action is commenced by filing a complaint with the court"].)

Cal.Comp.Cases 1743 (writ den.).) "Continuing failures and delays for providing medical care, for reimbursing payments made for providing medical care, and for medications to be provided through the pharmacy are separate and distinct acts supporting these additional, multiple penalties." (*Mote, supra*, 56 Cal.App.4th at p. 914.) Here, although each of the penalties was imposed by the WCJ for unreasonable delay in the provision of medical treatment, the penalties were for "separate and distinct unreasonable acts" by defendant. (*Christian, supra,* 15 Cal.4th at p. 511.) To hold otherwise would mean that a defendant who delayed a particular kind of medical treatment could then delay all other medical care without risk of additional penalty. That would directly conflict with the purpose of section 5814, to provide "an incentive to employers and insurance carriers to pay benefits promptly by making delays costly" and to "ameliorate the economic hardship on the injured employee that results from the delay in the provision of benefits...." (*Ramirez, supra*, 73 Cal.Comp.Cases at p. 1329.)

Defendant argues that all of the penalties were defective because the Opinion on Decision did not provide facts and reasoning in support of the WCJ's findings of unreasonable delay. We direct defendant to the WCJ's 43-page Report, which cured any alleged failure of the Opinion on Decision to satisfy the requirements of Labor Code section 5313. (*City of San Diego v. Workers' Comp. Appeals Bd. (Rutherford)* (1989) 54 Cal.Comp.Cases 57 (writ den.); *Smales v. Workers' Comp. Appeals Bd.* (1980) 45 Cal.Comp.Cases 1026 (writ den.).) Similarly, defendant argues that the WCJ's Opinion failed to explain why, for each penalty awarded, he found that applicant was entitled to the section 5814 statutory maximum of 25% of the medical treatment benefit delayed, not to exceed $10,000. Again, any defect was cured by the WCJ's Report. Sending this case back to the trial level for an expanded Opinion on Decision "would result in nothing but a wasteful spinning of the wheels." (See *Albert Van Luit Wallpaper Co. v. Workmen's Comp. Appeals Bd. (Taylor)* (1973) 36 Cal.App.3d 88, 92 [38 Cal.Comp.Cases 802, 804].)

The WCJ's Report makes it clear that he imposed the harshest penalties possible under section 5814 because of defendant's extensive history of delay in the provision of medical treatment; the effects of those delays on a paralyzed, catastrophically ill employee; the lengths of the various delays; and defendant's repeated failure to act when the delays were brought to its attention. (See *Ramirez, supra*, 73

Cal.Comp.Cases at pp. 1328-1331.) Indeed, defendant's broad and extended pattern of unreasonable delays rises to the level of "institutional neglect." (See, e.g., *County of San Luis Obispo v. Workers' Comp. Appeals Bd.* (*Barnes*) (2001) 92 Cal.App.4th 869, 877-878 [66 Cal.Comp.Cases 1261]; *Waters v. Workers' Comp. Appeals Bd.* (2000) 80 Cal.App.4th 652, 662 [65 Cal.Comp.Cases 484].)

Defendant's final contention concerning the penalties is that the WCJ's award of section 5814.5 attorneys' fees is not in compliance with the law and is not supported by the evidence. Defendant's argument that fees should not be awarded for certain briefing is premature, since the WCJ has not yet decided the amount of fees to be awarded. The WCJ has found only that fees will be assessed at $350.00 per hour, which defendant's petition does not challenge. Accordingly, defendant has waived any objection to that rate. (Lab. Code, §§ 5902, 5904.)

IV.

As an alternative basis for our decision, we conclude that defendant's individualized penalty contentions are each subject to denial for defendant's failure to adequately comply with WCAB Rules 10842, 10846, and 10852. (Cal. Code Regs., tit. 8, §§ 10842, 10846, 10852.) Rule 10846 provides that a petition for reconsideration may be denied "if it is unsupported by specific references to the record." (Cal. Code Regs., § 10846; see Cal. Code Regs § 10842(b) [petition "shall support its evidentiary statements by specific references to the record."].) Rule 10852 provides that a petition for reconsideration "shall set out specifically and in detail how the evidence fails to justify the findings," and Rule 10842 provides that a petition for reconsideration may be denied unless it "fairly state[s] all of the material evidence...." (Cal. Code Regs., tit. 8, §§ 10842(a), 10852.) In particular, Rule 10842(b) states:

> "(2) References to any documentary evidence shall specify: (A) the exhibit number or letter of the document; (B) the date and time of the hearing at which the document was admitted or offered into evidence; (C) where applicable, the author(s) of the document; (D) where applicable, the date(s) of the document; and (E) the relevant page number(s) and, if available, at least one other relevant identifier (e.g., line number(s), paragraph number(s), section heading(s)) that helps pinpoint the reference within the document (e.g., 'the 6/16/08 report of John A. Jones, M.D., at p. 7, Apportionment Discussion, 3rd full ¶ [Defendant's Exh. B, admitted at 8/1/08 trial, 1:30pm session]').

> "(3) References to any deposition transcript shall specify: (A) the exhibit number or letter of the document; (B) the date and time of the hearing at which the deposition transcript was admitted or offered into evidence; (C) the name of the person deposed; (D) the date and time of the deposition; and (E) the relevant page number(s) and line(s) (e.g., 'the 6/20/08 depo of William A. Smith, M.D., at 21:20-22:5 [Applicant's Exh. 3, admitted at 12/1/08 trial, 8:30am session]')." (Cal. Code Regs., tit. 8, § 10842(b).)

Here, well over 100 documentary exhibits were admitted into evidence.[11] Many of these were quite lengthy.[12] However, when describing the evidence for each factual argument, defendant's petition either: (1) made no reference to the record; (2) referred generally to a particular exhibit without any other identifier or page citation; and/or (3) identified a document and its page citation(s) but without identifying the exhibit number.

A petitioner for reconsideration cannot evade or shift its responsibility by attempting to place upon the Appeals Board the burden of discovering—without assistance from the petitioner—evidence in the record that supports its position. (See *Nielsen v. Workers' Comp. Appeals Bd.* (1985) 164 Cal.App.3d 918, 923-924 [50 Cal.Comp.Cases 104]; cf., *Grant-Burton v. Covenant Care, Inc.* (2002) 99 Cal.App.4th 1361, 1379 ("[i]t is the duty of a party to support the arguments in its briefs by appropriate reference to the record" and "[t]here is no duty on this court to search the record for evidence"); *Del Real v. City of Riverside* (2002) 95 Cal.App.4th 761, 768 ("[i]t is counsel's duty to point out portions of the record that support the position taken on appeal. The appellate court is not required to search the record on its own seeking error"); *Lewis v. County of Sacramento* (2001) 93 Cal.App.4th 107, 113–114 ("a busy court... cannot be expected to search through a voluminous record" and it is "not obliged to perform the duty resting on counsel" accordingly, "appellate counsel should be vigilant in providing [the court] with

---

[11] Applicant offered numbered exhibits through Exhibit 116 (although there were no Applicant's Exhibits 9, 11 through 15, 17, 18, 20 to 23, 34, 40, 66, 70, 78, 85, 88, 99, 104, 105, 107, and 108) and defendant offered lettered exhibits through Exhibit I (although Exhibits G, H and I were not admitted in evidence). However, many of the exhibits contained multiple documents. For example, Defendant's Exhibit A was actually five separate exhibits (i.e., A-1, A-2, A-3, A-4, and A-5). Similarly, many of applicant's exhibits included anywhere from two to five documents (e.g., Exhibits 92-A, 92-B, 92-C, 92-D, 92-E and Exhibits 110-A, 110-B, 110-C, 110-D, and 110-E).

[12] For example, the April 28, 2006 deposition of applicant (Defendant's Exhibit D) is 130 pages, the March 3, 2009 deposition of Theresa McDivitt (Applicant's Exhibit 109) is 144 pages, and the March 3, 2010 deposition of Susan Colleen Crane, RN (Applicant's Exhibit 111) is 55 pages long with some 20 pages of attachments.

effective assistance"); *Guthrey v. State of California* (1998) 63 Cal.App.4th 1108, 115 ("[t]he reviewing court is not required to make an independent, unassisted study of the record in search of error or grounds to support the judgment.").) Therefore, defendant's petition is alternatively denied for failure to comply with WCAB Rules 10842, 10846, and 10852.

Finally, as discussed earlier, this matter is being referred to the Audit Unit of the DWC. We shall provide the Audit Unit with copies of the WCJ's Supplemental Findings and Award and his accompanying Opinion on Decision, the WCJ's Report and Recommendation, and the Appeals Board's decision.

For the foregoing reasons,

IT IS ORDERED, as the Decision After Reconsideration of the Workers' Compensation Appeals Board, that the February 13, 2012 Supplemental Findings and Award is **AFFIRMED, EXCEPT** that it is **AMENDED** as follows:

/ / /

/ / /

/ / /

/ / /

/ / /

/ / /

/ / /

/ / /

/ / /

/ / /

/ / /

/ / /

/ / /

/ / /

Findings of Fact No. 8 is amended as set forth below:

FINDINGS OF FACT

8. The defendant did unreasonably delay reimbursement to HMS/Department of Health Services, entitling applicant to increased compensation under Labor Code section 5814 of 25% of the medical treatment benefit delayed, not to exceed $10,000, payable to the applicant's personal representative or heir under Labor Code section 4700. This delayed reimbursement does not include any treatment incurred at St. John's Regional Medical Center and subject to the penalty imposed by Finding 12.

WORKERS' COMPENSATION APPEALS BOARD

DEPUTY

NEIL P. SULLIVAN

I CONCUR,

FRANK M. BRASS

DEIDRA E. LOWE

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

APR 16 2013

SERVICE MADE ON THE ABOVE DATE ON THE PERSONS LISTED BELOW AT THEIR ADDRESSES SHOWN ON THE CURRENT OFFICIAL ADDRESS RECORD.

BRADFORD BARTHEL
ERNEST CANNING
RALPHS GROCERY CO
SEDGWICK CLAIMS MANAGEMENT
DWC AUDIT UNIT

CNF:jmp

WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

CHARLES ROMANO (Deceased), ***Applicant,*** **vs.** **RALPHS GROCERY COMPANY, Permissibly Self-Insured and Administered by SEDGWICK CMS,** ***Defendants.***	**Case No. ADJ1372133 (VNO 0488219)** **OPINION AND ORDER GRANTING RECONSIDERATION**

Reconsideration has been sought by defendant, with regard to a decision filed on February 13, 2012.

Taking into account the statutory time constraints for acting on the petition, and based upon our initial review of the record, we believe reconsideration must be granted in order to allow sufficient opportunity to further study the factual and legal issues in this case. We believe that this action is necessary to give us a complete understanding of the record and to enable us to issue a just and reasoned decision. Reconsideration will be granted for this purpose and for such further proceedings as we may hereinafter determine to be appropriate.

For the foregoing reasons,

IT IS ORDERED that the Petition for Reconsideration is **GRANTED**.

/ / /

/ / /

/ / /

/ / /

/ / /

/ / /

/ / /

IT IS FURTHER ORDERED that pending the issuance of a Decision After Reconsideration in the above case(s), all further correspondence, objections, motions, requests and communications shall be filed in writing only with the Office of the Commissioners of the Workers' Compensation Appeals Board at either its street address (455 Golden Gate Avenue, 9th floor, San Francisco, CA 94102) or its Post Office Box address (PO Box 429459, San Francisco, CA 94142-9459), and shall *not* be submitted to the Van Nuys District Office or any other district office of the WCAB and shall *not* be e-filed in the Electronic Adjudication Management System.

WORKERS' COMPENSATION APPEALS BOARD

DEPUTY

NEIL P. SULLIVAN

I CONCUR,

DEIDRA E. LOWE

FRANK M. BRASS

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

MAY 07 2012

SERVICE MADE ON THE ABOVE DATE ON THE PERSONS LISTED BELOW AT THEIR ADDRESSES SHOWN ON THE CURRENT OFFICIAL ADDRESS RECORD.

BRADFORD & BARTHEL
LAW OFFICES OF ERNEST A. CANNING

CNF/bgr

CASE NO. ADJ 1372133 [VNO 0488219]

CHARLES ROMANO	v.	RALPHS GROCERY COMPANY; PERMISSIBLY SELF-INSURED
DATE OF INJURY:		DECEMBER 20, 2003
WORKERS' COMPENSATION JUDGE:		RALPH ZAMUDIO
DATE:		APRIL 3, 2012

REPORT OF WORKERS' COMPENSATION JUDGE
ON PETITION FOR RECONSIDERATION

INTRODUCTION

Applicant, Charles Romano, now deceased, born 12/12/1960, while employed on December 20, 2003, as a stocker, occupational group #360, at Camarillo, California, by Ralphs Grocery Company, then Permissibly Self-Insured, sustained injury arising out of and in the course of employment to the left shoulder, cervical spine, with subsequently industrially-related staph infection resulting in a compensable consequence injury to the neck, cardiovascular system, pulmonary system, thoracic spine (with resulting paralysis) and as a further compensable consequence injury to urinary/fecal incontinence, renal failure, psyche, and vision (bilateral retinal hemorrhages).

The defendant timely filed a verified petition for reconsideration on 3/9/2012 of the Supplemental Findings and Award (Medical Treatment Penalties & L.C. §§ 5814, 5814.5) served on 2/13/2012, which found, in pertinent part, no good cause to allow defendant to withdraw from a 1/15/2009 trial stipulation to present testimony in the form of depositions, and found that defendant unreasonably delayed provision of medical treatment resulting in eleven (11) separate medical treatment penalties under

Labor Code section 5814, each in the sum "of 25% of the medical treatment benefit delayed not to exceed $10,000, payable to the applicant's personal representative or heir under Labor Code section 4700," and an award of Labor Code section 5814.5 attorney fees payable by defendant "in an amount to be determined by the parties at the hourly rate of $350."

The defendant asserts that by the order, decision or award, the board acted without or in excess of its powers, the evidence does not support the findings of fact, and the findings of fact do not support the order, decision or award.

The defendant contends (1) the multiple medical treatment penalty claims now advanced by the applicant's personal representative or heirs under Labor Code section 4700 do not survive the death of applicant, (2) the multiple penalty claims are barred by Labor Code section 5814(g), (3) the number of penalties imposed is excessive and violates the principles of Section 5814, (4) the findings and award fails to set forth sufficient basis for awarding the maximum Section 5814 penalty for each alleged penalty, (5) the findings and award of eleven medical treatment penalties is not supported by substantial evidence as there is no evidence set forth in the decision to support a finding of unreasonable delay as to each alleged medical treatment penalty claim, (6) there is error in not setting aside the parties' stipulation to utilize deposition testimony in lieu of live testimony, and (7), if any penalties are found, the findings and award of attorney's fees under Section 5814.5 is not in compliance with the law nor supported by substantial evidence.

The applicant filed a detailed answer to the petition for reconsideration disputing each contention raised by defendant.

Due to the complexity and history of this case, both the defendant and applicant concurrently filed with the petition for reconsideration and answer to the petition for

reconsideration separate petitions each seeking leave of the board to exceed the 25-page limitation under WCAB Rule 10845(b) and Rule 10232(a)(10).

FACTS

The applicant suffered an industrial injury to the left shoulder on 12/20/2003 while employed as a stocker by defendant, Ralphs Grocery Company. The applicant also alleged injury to the cervical spine, with subsequent industrially-related staph infection resulting in a compensable consequence injury to the neck, cardiovascular system, pulmonary system, thoracic spine (with resulting paralysis) and as a further compensable consequence injury to urinary/fecal incontinence, renal failure, psyche, and vision (bilateral retinal hemorrhages).

The applicant suffered a myocardial infarction on 3/2/2004 and was admitted to St. John's Regional Medical Center (SJRMC). (As noted below, when the disputed issue of parts-of-body injured was initially adjudicated in 2006, the WCJ found the 2004 heart attack not industrially-related as alleged by applicant.)

The applicant underwent a left shoulder surgery on 8/29/2005 performed by Dr. Andrew Rah. He referred the applicant for follow-up physical therapy at the Burnwall Clinic whose records document complaints of pain to the shoulder, and among other things, "red, raised areas" around the left shoulder in October of 2005. He was hospitalized beginning on 11/7/2005 at Ventura County Medical Center due to complaints of chest pain, and two weeks of fever and coughing of purulent sputum. The applicant's condition rapidly deteriorated and within a week he was noted to have lost all sensation, motor function and reflexes from below his nipple line. It was confirmed he was infected by Methicillin-Resistent Staphylococcus Aureus (MRSA) which resulted in septicemia, endocarditis pneumonia, renal and pulmonary failure and diskitis at C7-T1, deep vein thrombosis in the left lower extremity with pulmonary embolism, retinal

hemorrhages, and total paralysis from C8 down. The paralysis affected not only the extremities but also the chest wall muscles which assist with breathing. He remained hospitalized at VCMC until 7/1/2006 as noted below.

While hospitalized at Ventura County Medical Center from 11/7/2005 to 7/1/2006, applicant was bedridden during said hospital stay. Because the defendant was disputing the industrial-relatedness of the MRSA infection, the defendant did not authorize treatment at VCMC. The VCMC hospitalization was paid for by Medi-Cal.

Upon his discharge, the applicant self-procured treatment at County Villa Oxnard Manor. Said facility failed to adequately care for the applicant such that the applicant's friend, Sid Freeman, was compelled to call 911 after receiving an emergency call from the applicant indicating he was very ill. Upon entering the applicant's room, Mr. Freeman saw "his Foley catheter bag was full of blood." As a result, applicant was hospitalized at St. John's Regional Medical Center where he was found to have "a horrible infection in his bladder." He sustained a second myocardial infarction on 9/2/2006, was hospitalized at SJRMC and discharged on 9/7/2006. The hospital records show his clinical course was complicated by ongoing infections and paraplegia making him a poor surgical candidate. He was again hospitalized at SJRMC from 11/22/2006 to 11/25/2006 "for evaluation of hypotension and possibly UTI." The hospital records further noted, "His cultures were positive for MRSA, in urine, small abdominal would and blood."

The case was tried before WCJ Mark Huang on 8/9/2006 on limited issues related to the nature and extent of the applicant's injuries, including whether the original industrial injury of 12/20/2003 included injury to the cervical spine, and whether the 2004 myocardial infarction and the MRSA infection were related to the industrial injury.

The WCJ issued an Amended Findings and Award on 10/25/2006, finding the applicant did suffer industrial injury on 12/20/2003 to the "left shoulder and cervical spine with subsequently industrially related staph infection resulting in a compensable consequence injury to his neck, cardiovascular system, pulmonary system, thoracic spine with resulting paralysis." The WCJ also found, among other things, the applicant is in need of "further medical treatment to cure or relieve from the effects of the injury herein limited to his left shoulder, cervical spine and consequences of his staph infection." The WCJ ordered the defendant to "pay or adjust all reasonable medicals and medical-legal liens of record with the court to retain jurisdiction per stipulation of the parties." [The defendant's petition for reconsideration of the WCJ's decision was denied by the Appeals Board on 12/14/2006. The defendant's Petition for Writ of Review was denied on 6/9/2007.]

The defendant delayed and/or failed to make reimbursement to SJRMC for the above-noted 2006 hospitalization notwithstanding applicant's demand letter of 5/8/2007 enclosing SJRMC bill dated 3/8/2007 (Exhs. 68-A, 68-B), and the filing of liens with supporting itemization by SJRMC dated 11/20/2007 (Exh. 69-B) and dated 8/21/2008 (Exh. 69-A). The claims adjuster admitted she had no recollection of any effort to either pay or adjust the SJRMC bills. (Exh. 109, Vol. 1 McDivitt Dep., 126:13-128:22). The applicant was transported to SJRMC on 11/22/2006 and back from the hospital on 11/25/2006 by Gold Coast Ambulance. The defendant was served with the Gold Coast bills on 4/16/2007 (Exh. 77-A). The defendant refused payment of the bills.

On 10/31/2006, Dr. Arthur Harris requested authorization to refer the applicant to Dr. Hedge, a spinal cord specialist at "Northridge Spinal Cord Injury Center" [the correct name of the facility is Pacific Region Spinal Injury Care System, Northridge Hospital Medical Center].

In January of 2007, Theresa McDivitt, a Sedgwick litigation specialist, was assigned the applicant's case. The claims adjuster was aware of the Amended Findings and Award of 10/25/2006, and knew the future medical award included medical care for the cardiovascular system, and that the WCJ had found injury to the pulmonary system and that the MRSA infection had caused pulmonary and renal failure which required resuscitation, and that the WCJ found the injury had caused paralysis, and knew he was entitled to treat the devastating sequelae of the MRSA infection. She understood based upon her thirty-one years of experience in workers' compensation that an employer's responsibility to provide medical care is not apportioned. (Exh. 109, Vol. 1 McDivitt Depo., pp. 16-22).

The defendant delayed referring the applicant to the recommended spinal cord injury center until February of 2007 at which time, accompanied by Nurse Case Manager Suzanne Crane, RN, the applicant was evaluated by the Medical Director, Dr. Joel Rosen, a board certified specialist in physical medicine and rehabilitation. Dr. Rosen issued a report dated 2/12/2007 setting forth his medical findings, and recommended the applicant be admitted "to Northridge Hospital in the spinal injury rehabilitation program so that he can receive a comprehensive regarding the above [multiple medical] issues, as well as being involved in an appropriate rehabilitation upgrading program." He specifically noted applicant's need for a cardiac evaluation.

The applicant was hospitalized at Northridge Hospital and under the care of Dr. Rosen from 2/28/2007 to 9/13/2007, and during the hospital stay he was referred to specialists in pulmonary, infectious disease, cardiology, podiatry, urology, orthopedic, psychology and psychiatry. His length of stay was extended by several factors including not only medical complications but the claims administrator's delay in furnishing a special motorized wheelchair with tilt, and resistance to authorizing the

procuring of a BiPAP machine, without which Dr. Rosen refused to discharge the applicant and transferring him to Care Meridian, an attendant care facility in Oxnard where the applicant would have immediate access to 24/7 nursing care and visits from a single physician once a week. Dr. Rosen issued a report dated 7/11/2007 setting forth the nature of the skilled care and medical supervision the applicant would require upon his discharge from Northridge Hospital. While at Northridge Hospital, Suzanne Crane, R.N., was the assigned Nurse Case Manager employed by CorVel. Her services were terminated on 9/14/2007. The claims adjuster denies she terminated NCM Crane's services, and asserts the Nurse Case Manager "closed her file" because nurse case management services would be furnished by Care Meridian. The Nurse Case Manager Crane denied telling the claims adjuster the applicant would no longer require the services of a NCM or that those services would be provided by Care Meridian, and testified at her deposition her nurse case management services ended because the defendant did not want to work with her company anymore. (Exh. 111, Crane Depo., pp. 40-41.).

Upon the applicant's transfer to Care Meridian on 9/13/2007, the applicant came under the care of Dr. Robert Feiss, the sole physician at Care Meridian. On 11/27/2007, Dr. Feiss issued a prescription for a cardiologist consult which was served upon the defendant on 11/28/2007.

Dr. Rosen was deposed on 12/6/2007, and gave extensive testimony about his medical findings and the applicant's needs, including that the treatment furnished at Northridge Hospital and at SJRMC was reasonable and necessary to cure or relieve the effects of the industrial injury, and how the second myocardial infarction was industrial.

On 12/19/2007, Dr. Feiss issued a prescription for a wheelchair accessible van for therapeutic outings, attending church and community re-entry (Exh. 59-B). While at Care Meridian, only limited transportation was provided to applicant which required his friend Sidney Freeman to rent a vehicle. Because the defendant did not comply with the prescription for the wheelchair accessible van, the applicant later self-procured the purchase of a van. The defendant was served with the prescription and copy of applicant's check for the self-procured van via applicant's attorney's letter to defense counsel dated 12/19/207 (Exh. 59-A). The defendant made no payments in response to the request for reimbursement for the self-procured van.

On 1/4/2008, Dr. Feiss issued a prescription for a nurse case manager "to serve and assist in coordination of patient care between medical providers and claims administrator." (Exh. 61-B). The defendant, having terminated the services of NCM Crane on 9/13/2007 refused to provide the requested NCM after service of the prescription and written demand for same was made by applicant via letter dated 1/15/2008. (Exh. 62) until 2/7/2008. Hence, there was an approximate four and one-half month delay in provision of nurse case manager treatment services.

To address disputed medical issues, the defendant obtained rebuttal medical report of Dr. Edward O'Neill who opined on 1/25/2008 there was no clear relationship between the applicant's MRSA infection of 2005 and the second heart attack occurring in 2006. He disagreed with Dr. Joel Rosen's opinion the second heart attack was related to the MRSA infection.

The applicant remained at Care Meridian until approximately late April of 2008 when he was hospitalized at Community Memorial Hospital (CMH) where he died on 5/2/2008 from cardiorespiratory arrest, respiratory failure and MRSA pneumonia. The defendant did not authorize the hospitalization at CMH. After receiving applicant's

6/8/2008 demand for payment of the hospital bill, the defendant did not make payment until 10/24/2008, a delay of four and one-half months. While at CMH, the applicant underwent diagnostic testing on 5/7/2008, 5/8/2008, 5/13/2008 performed by Community Imaging Medical Group. The defendant did not authorize the diagnostic testing. The defendant was served with the diagnostic testing bill dated 5/14/2008 by applicant's attorney on 6/8/2008. The defendant took no action as to payment of the bill following its receipt of the bill in June of 2008. At her deposition taken on 3/3/2009, the claims adjuster was uncertain whether the Community Imaging Medical Group bill had been paid. (1 McDivitt Depo., pp. 105-106).

With respect to the Medi-Cal lien of HMS/Department of Health Services filed in the sum of $275,439.14 (for the above-noted self-procured treatment at VCMC, various pharmacies, and at SJRMC) the defendant was served with the Medi-Cal lien on 10/25/2007, but did not settle or adjust the lien until 7/23/2008, a delay of approximately nine months.

During the applicant's treatment at Care Meridian, Dr. Robert Feiss prescribed a psychiatric consultation on 10/30/2007 and for Doppler Studies which were mailed and faxed to the defendant on 11/6/2007. The defendant produced no admissible evidence it ever authorized the psychiatric consult and Doppler Studies.

Prior to his death, the applicant issued a Declaration of Trust creating "The Romano Trust" dated 9/10/2007 which named as trustee, Mr. Dan Yonovitz. An Order Joining The Romano Trust by and through its Trustee, Dan Yonovitz as Party Applicant issued on 5/4/2008.

The case last came on the trial calendar to adjudicate remaining disputed issues relating to earnings, parts-of-body injured, liability for self-procured medical treatment, including out-of-pocket Guardian Ad Litem expense, attorney fees, applicant's claim for

multiple Labor Code section 5814 medical treatment penalties (12), Labor Code section 5813 sanctions and attorney fees, Labor Code section 5814.6 referral to Administrative Director for Audit Penalty, Labor Code section 5814.5 attorney fees, and whether the applicant's disputed medical treatment penalty claims survive the death of applicant.

Relevant to the pending disputed multiple penalty claims, the applicant filed on 4/23/2007 an Applicant's Trial Brief dated 4/21/2007, on 2/6/2008 a Supplement To Petition For Award Enforcement; For Penalties And For Reasonable Attorney's Fees; For Imposition Of Sanctions And For An Order That Defendant Appear And Show Cause Why It Should Not Be Held In Contempt; For Referral To Administrative Director For Determination Whether A Penalty Should Be Imposed Pursuant To Labor Code § 5814.6 dated 1/28/2008, on 2/19/2008 a Second Supplement To Petition For Award Enforcement, Penalties, Attorney Fees, Sanctions And OSC Re Contempt dated 2/15/2008, and on 9/18/2008 a Revised and Amended Petition For Award Enforcement; For Penalties And For Reasonable Attorney's Fees; For Imposition Of Sanctions And For A Referral To The Administrative Director For Determination Whether A Penalty Should Be Imposed Pursuant To Labor Code § 5814.6 dated 9/4/2008.

The defendant filed on 2/15/2008 a Defendant's Response To Applicant's Petitions For Award Enforcement And Penalties Dated 11/20/07, 12/7/07 & 1/28/08 dated 2/14/2008.

The applicant filed a trial brief regarding earnings dated 9/8/2008, a supplemental trial brief dated 10/23/2008, a final supplement to trial brief dated 6/13/2010, and an "Applicant's Reply To Defendant's 1st Amended Trial Brief; Supplemental Points & Authorities; Opposition To Motion To Set Aside Stipulation And Order To Use Deposition Testimony In Lieu Of Trial Testimony" dated 1/31/2011.

The defendant filed a preliminary trial brief dated 9/10/2008, a supplemental trial brief dated 11/4/2008, a "Defendant's Trial Brief In Response To Applicant's Final Supplemental Trial Brief And Points And Authorities" dated 7/30/2010, a "1st Amended Defendant's Trial Brief In Response To Applicant's Final Supplemental Trial Brief And Points And Authorities" dated 12/20/2010, a "Defendant's Response To Minutes Of Hearing" dated 1/25/2011, and a "Motion To Set Aside Stipulation To Utilize Deposition Testimony In Lieu Of Live Testimony Of Claims Examiner Theresa McDivitt" dated 1/25/2011. The defendant filed an "Objection For Order Allowing Attorneys Fees . . ." dated 3/7/2011 objecting to applicant's attorney's request for an order allowing fees at the hourly rate of $350.00. [This objection appears to erroneously reference a fee request under L.C. § 5710 rather than under L.C. §§ 5814.5 and 5813 as requested by applicant.] By further supplemental trial brief in response thereto by letter dated 3/9/2011 received by this board on 3/11/2011, the applicant argued why an attorney fee at the hourly rate of $350.00 should be allowed.

Following issuance of Supplemental Findings and Award (Medical Treatment Penalties & L.C. §§ 5814, 5814.5) dated 5/31/2011, awarding some medical treatment penalties and denying others, the applicant timely filed a petition for reconsideration on 6/8/2011 contending there was error in the failure to assess medical treatment penalties for delay in providing "prescribed wheelchair with tilt" and in "reimbursement of self-procured and out of pocket expenses, including reimbursement for wheelchair accessible van" and in finding no unreasonable delay in reimbursement of self-procured medical treatment received from St. John's Regional Medical Center, and error in "failing to make express finding that employer is obligated to reimburse out of pocket expense for self-procured, wheelchair accessible van" and error in failing to assess attorney's fees against previously awarded TD indemnity.

In accordance with WCAB Rule 10859, an Order Rescinding Supplemental Findings and Award issued on 6/17/2011 setting the matter for further proceedings to further address applicant's contentions, including possible further development of the record.

Prior to defendant's receipt of the Order Rescinding Supplemental Findings and Award, the defendant timely filed a petition for reconsideration on 6/23/2011 of the supplemental findings and award of Labor Code section 5814, 5814.5 contending error in the award of multiple medical treatment penalties, attorney fees and the denial of its motion to allow for live testimony of witnesses. Because the order rescinding rendered moot the applicant's and defendant's petitions for reconsideration, the appeals board dismissed their petitions for reconsideration by its Order Dismissing Petitions For Reconsideration dated 7/19/2011.

Thereafter, the parties appeared before the undersigned WCJ on 7/18/2011 at which time the applicant filed Applicant's Final Trial Brief dated 7/17/2011, and filed a Second Supplemental Declaration of Ernest A. Canning dated 7/18/2011. Because the appeals board had not yet acted on the then pending petitions for reconsideration, the matter was continued to 8/24/2011, and in the interim the defendant was giving opportunity to file written response to the applicant's trial brief filed on 7/18/2011. The defendant filed on 8/24/2011 Defendant's Reply to Applicant's Final Trial Brief, and filed on 8/24/2011 a written request for admission of live testimony of Monica Bender and Brandy Freeman of Care Meridian. The defendant also filed on 8/24/2011 a written request for admission of additional exhibits. Because the undersigned WCJ was on jury duty on 8/24/2011, the matter was continued to 11/10/2011.

The Minutes of Hearing dated 11/10/2011 set forth in detail at pages 2:24-8:7 the additional oral argument made by the parties regarding defendant's motion to reopen

the record for the taking of live testimony of Monica Bender, Brandy Freeman, Teresa McDivitt and applicant's objection thereto, and the taking into evidence additional documents (Defendant's Exhibits G, H, I, Marked for ID Only). Additional supplemental declarations of Ernest A. Canning dated 7/18/2011 and 11/9/2011 were received in evidence (Applicant's Exhibits 115 and 116). Also noted in said Minutes of Hearing is that the defendant filed a Defendant's Objection To 5814.5 Attorney Fees dated 11/8/2011, and the applicant filed on 11/10/2011 a Reply To Objection To 5814.5 Attorney Fees dated 11/9/2011. The motion to allow for the admission into evidence the additional defense exhibits and the taking of live testimony was taken under submission together with the other issues.

Voluminous documents were received in evidence, including but not limited to medical records and reports of Dr. Edward O'Neill, Dr. Darrell Burstein, Dr. Alan Gross, Dr. Joel Rosen, Dr. Kevin Pidgeon, Dr. Richard Myer, Dr. Raj Wick, Dr. Ronald Tung, Dr. Walter Jacobson, Dr. K. Fields, Dr. Gregory Franz, Dr. Esam Obed, Dr. Bruce Toporoff, Dr. Edward Morales, Dr. Adam Sherman, Dr. David Friend, Dr. Jeffrey Allan, Dr. Warren Procci, Dr. Robert Feiss, Dr. Tara Snow, Dr. Diane Li, Dr. Marc Reynoso, Dr. Thomas Brugman, depositions of Charles Romano dated 7/7/04 & 4/28/06, Dr. Joel Rosen dated 12/6/07, Randy Marks dated 3/21/08, Theresa McDivitt dated 3/3/09 & 7/7/09, Suzanne Crane, R.N. dated 3/3/10, and Sidney Freeman dated 3/3/10, Nurse Case Manager reports of Suzanne Crane, R.N., prescription slips, invoices, emails, lien objection letters, bills, liens, printout of benefits, correspondence, and Declarations of Ernest Canning, Esq., as itemized in the Minutes of Hearing dated 2/3/2011 at pages 2:16-17:24, the Order Admitting Documentary Evidence dated 2/16/2011, and the Minutes of Hearing dated 11/10/2011.

The undersigned WCJ considered the defendant's motion to set aside the stipulation to utilize deposition testimony in lieu of live testimony and its request that submission of the matter be vacated to allow for live testimony of the claims supervisor, Theresa McDivitt, to rebut "any bias that has been generated through the deposition transcript by other witnesses and that can only be done by live testimony." The undersigned WCJ also considered the defendant's motion dated 8/24/2011 and oral motion presented at the hearing held on 11/10/2011 to allow for live testimony of witnesses, Monica Bender, Brandy Freeman and Theresa McDivitt. The applicant opposed the defendant's motions. As noted by applicant, at a trial held on 1/15/2009, by Minute Order the trial was held in abeyance so that the parties could present trial testimony by way of depositions wherein the parties documented in the Minutes of Hearing at page 4, as follows:

> "Parties agree to present trial testimony by way of depositions to be taken at defense counsel's office on mutually agreed dates at defendant's expense. The depositions are of Teresa [sic] McDivitt, Suzanne Crane, R.N., and Sid Freeman. These Depositions & the already completed depositions of Randy Marks will be offered in lieu of direct trial testimony. Matter is to be taken off calendar pending completion of Depositions at which point it may be reset for trial before WCJ R. Zamudio without need for an additional MSC."

After reviewing the entire voluminous record, and the additional post-trial briefs and reply briefs, and based upon review of the record, including but not limited to the medical reports of Dr. Edward O'Neill, Dr. Darrell Burstein, Dr. Alan Gross, Dr. Joel Rosen, Dr. Kevin Pidgeon, Dr. Richard Myer, Dr. Raj Wick, Dr. Ronald Tung, Dr. Walter Jacobson, Dr. K. Fields, Dr. Gregory Franz, Dr. Esam Obed, Dr. Bruce Toporoff, Dr. Edward Morales, Dr. Adam Sherman, Dr. David Friend, Dr. Jeffrey Allan, Dr. Warren Procci, Dr. Robert Feiss, Dr. Tara Snow, Dr. Diane Li, Dr. Marc Reynoso, Dr. Thomas

Brugman, Depositions of Charles Romano dated 7/7/04 & 4/28/06, of Dr. Joel Rosen dated 12/6/07, of Randy Marks dated 3/21/08, of Theresa McDivitt dated 3/3/09 & 7/7/09, of Suzanne Crane, R.N. dated 3/3/10, and of Sidney Freeman dated 3/3/10, and the Nurse Case Manager reports of Suzanne Crane, R.N., prescription slips, invoices, emails, lien objection letters, bills, liens, printout of benefits, correspondence, and Declaration of Ernest Canning, Esq., and the more persuasive and convincing written argument and points and authorities set forth in the above-noted applicant's multiple trial briefs and written argument over those submitted by defendant, whose argument and reasoning was incorporated by reference in the WCJ's Opinion on Decision, the undersigned WCJ issued the Supplemental Findings and Award (Medical Treatment Penalties & L.C. §§ 5814, 5814.5) in favor of the applicant, awarding, in pertinent part, eleven separate medical treatment penalties for:

(1) unreasonable delay of medical treatment in the form of motorized wheelchair with tilt, (2) unreasonable delay of medical treatment in the form of Bi-PAP machine, (3) unreasonable delay of medical treatment in the form of hospitalization at Community Memorial Hospital, (4) unreasonable delay in authorization and payment of Community Imaging bill, (5) unreasonable delay of reimbursement to HMS/Department of Health Services liens, (6) unreasonable delay of medical treatment in the form of venous/Doppler studies and psychiatric consultation, (7) unreasonable delay in reimbursement of wheel chair accessible van, the reasonable value of said van being the sum of $35,000, (8) unreasonable delay in appointment of a nurse case manager upon applicant's discharge from Northridge Hospital in September of 2007, (9) unreasonable delay in reimbursement of self-procured treatment from St. John's Regional Medical Center, (10) unreasonably delay or refusal of medical treatment in the form of Gold Coast Ambulance transportation expense for services rendered on

11/25/2006 and 11/5/2007, and (11) unreasonably delay or refusal of medical treatment in the form of reimbursement to applicant's Guardian Ad Litem, Jo Ann Richards, for expense and time required to transport and remain with the applicant at medical appointments while serving as Guardian Ad Litem from 1/30/2006 to 10/9/2007.

As to each of the above-noted eleven separate medical treatment penalties awarded it was found the applicant is entitled to increased compensation under Labor Code section 5814 of 25% of said medical treatment benefit service reimbursement delayed or refused not to exceed $10,000, payable to the applicant's personal representative or heir under Labor Code section 4700. The defendant's contention the increased compensation medical treatment penalty claims do not survive the applicant's death and are not payable to the Labor Code section 4700 personal representative was rejected.

The applicant was also awarded a Labor Code section 5814.5 attorney fee, payable by defendant in an amount to be determined at the hourly rate of $350.00 as a reasonable attorney fee incurred in perfecting the above-referenced multiple medical treatment penalties.

The defendant's motion to allow for the admission into evidence of additional defense exhibits and the taking of live testimony was also denied.

It is from the Supplemental Findings and Award (Medical Treatment Penalties & L.C. §§ 5814, 5814.5) of 2/13/2012 the defendant now seeks reconsideration.

DISCUSSION

The defendant, among other things, contends the supplemental findings and award of multiple medical treatment penalties under Labor Code section 5814 in favor of the deceased applicant's Labor Code section 4700 personal representative or heir is

erroneous because the disputed medical treatment penalty claims under Labor Code section 5814 do not survive his death on May 2, 2008. Labor Code section 4700 provides as follows:

> "The death of an injured employee does not affect the liability of the employer under Articles 2 (commencing with Section 4600) and 3 (commencing with Section 4650). Neither temporary nor permanent disability payments shall be made for any period of time subsequent to the death of the employee. Any accrued and unpaid compensation shall be paid to the dependents, or if there are no dependants, to the personal representative of the deceased employee or heirs or other persons entitled thereto, without administration."

Because Labor Code section 5814 is not a part of Articles 2 or 3, any increased compensation due under said statute does not survive the applicant's death argues the defendant.

Labor Code section 4700 provides jurisdiction to issue an award for medical treatment penalties and attorney's fees to the applicant's personal representative or heir because the penalties on medical treatment attach to the Labor Code section 4600 benefit under Article 2, and are a form of increased compensation and not a separate class of benefit. As noted by applicant in the answer to the petition for reconsideration, indemnity benefits, medical treatment benefits and penalties "have long been recognized as 'compensation' within the meaning of Labor Code § 3207." (*Ramirez v. Drive Financial Services* (2008) 73 Cal. Comp. Cases 1324, 1331 (board en banc); *Dubois v. Workers' Comp. Appeals Bd.* (1993) 5 Cal.4th 382 [58 Cal. Comp. Cases 286]; *State of California v. Workers' Comp. Appeals Bd. (Ellison)* (1996) 44 Cal.App.4th 128 [61 Cal. Comp. Cases 325, 334].) The courts have consistently construed penalties to be part and parcel of the unreasonably delayed form of compensation to which they attach. (*Mote v. Workers' Comp. Appeals Bd.* (1997) 56 Cal.App.4th 902 [62 Cal. Comp. Cases 891, 896].)

Here, the need for medical treatment and penalties arising from the employer's unreasonable refusal and/or delay of the medical treatment benefit arose during the applicant's lifetime. The applicant correctly notes in *Dubois, supra*, 58 CCC at 297, the court observed, ". . . section 5814 was enacted as an inducement to prompt payment on the part of private employers and their insurers, which would otherwise have an economic incentive to delay or deny the payment of workers' compensation benefits." The Section 5814 penalty "is designed to help an employee obtain promptly the cure or relief he is entitled to under the law, and to compel his employer to provide this cure or relief in a timely fashion." (*Adams v. Workers' Comp. Appeals Bd.* (1976) 18 Cal.3d 226, 229 [41 Cal. Comp. Cases 680, 682].) The defendant's strict interpretation of section 4700 would frustrate the policy of insuring the prompt and timely provision of indemnity and medical treatment benefits to injured workers. Liberal construction does not support the defendant's contention that the applicant's right to medical treatment penalties does not survive his death. Defendant's assertions are without merit.

The defendant further contends the medical treatment penalty claims are barred by Labor Code section 5814(g) because they were not timely filed or "heard" within two years from the date any compensation may have been due. It argues the applicant died on 5/2/2008, and so his Labor Code section 4700 personal representative [The Romano Trust] "only had until May 12 [sic], 2010, at the latest, to have the matter heard." It further argues, even if the filing of applicant's petition for penalties is enough to toll the statute of limitations, "many of the events that form the basis of Applicant's penalty claims occurred outside of two years from the filing of the September 2008 penalty petition, specifically, the claim of penalty for the alleged failure timely to reimburse the Guardian ad Litem." It argues the bulk of the GAL expenses were incurred in 2006 so any penalty for expenses incurred prior to 9/2008 is time-barred.

Labor Code section 5814(g) provides:

> "(g) Notwithstanding any other provision of law, no action may be brought to recover penalties that may be awarded under this section more than two years from the date the payment of compensation was due."

In framing the admitted facts and issues at trial on 12/20/2010, the defendant failed to raise the issue of statute of limitations on the penalty claims under Labor Code section 5814(g). The same is true for the hearings held on 2/3/2011 and 11/10/2011. Having failed to do so, the defendant waived the defense. Assuming, *arguendo*, there was no waiver because the Section 5814(g) defense is referenced in defendant's trial brief or briefs, the applicant did file penalty petitions dated 12/26/2006, 11/20/2007, 12/7/2007 and supplemental petitions dated 1/28/2008, 2/15/2008, 5/14/2008, 9/8/2008 as noted at pages 9-10 of the applicant's verified answer to the petition for reconsideration. In his answer to the petition for reconsideration, the applicant explains the 9/8/2008 revised and amended petition only seeks penalties for the post-award delays that occurred after this board denied the defendant's petition for reconsideration on 12/14/2006. The unreasonable delays found herein occurred within two-years of the amended petitions. As further noted by applicant in the answer to the petition for reconsideration, the first trial setting with respect to the post-award penalty claims was set in 2008, a date within two-years of the claimed delays. There is no merit to the contention Labor Code section 5814(g) bars the multiple medical treatment penalties awarded herein.

With respect to the award of eleven separate medical treatment penalties, there is substantial evidence to support the award. Labor Code section 5814(a) provides as follows:

> (a) When payment of compensation has been unreasonably delayed or refused, either prior to or subsequent to issuance of an award, the

amount of the payment unreasonably delayed or refused shall be increased up to 25 percent or up to ten thousand dollars ($10,000), whichever is less. In any proceeding under this section, the appeals board shall use its discretion to accomplish a fair balance and substantial justice between the parties."

When the payment or furnishing of any compensation benefit has been unreasonably delayed or refused, either prior to or subsequent to the issuance of an award, the applicant is entitled to seek increased compensation under the statute. The only satisfactory excuse for a delay in, or failure to make payment of, a benefit is that there exists genuine doubt from a medical or legal standpoint as to a defendant's liability for the same. (Labor Code section 5814; *Kerley v. Workers Comp. Appeals Bd.* (1971) 4 Cal.3d 273, [36 Cal. Comp. Cases 152].)

Wheelchair with tilt

The defendant contends the four-month delay between the time defendant's UR department certified as medically necessary and appropriate the purchase of a motorized wheelchair with tilt on 4/26/2007, and the time it was delivered to the applicant at Northridge Hospital on 8/27/2007 was reasonable because the adjuster had to investigate whether defendant needed to purchase or rent the chair, pricing, and upon selection of a vendor what additional accessories were needed and have the applicant's treating physician, Dr. Rosen, address the necessity of the additional accessories. It argues the Nurse Case Manager, Suzanne Crane, RN, was not necessarily in the loop once the matter had been assigned to the vendor, Medical Services Company, and so her testimony should not be given full weight. It argues the adjuster, Theresa McDivitt, was concerned about the need for the wheelchair at the Northridge Hospital because she understood he had access to a wheelchair at the hospital and there were reports the applicant was non-compliant and refusing to get out of bed. The defendant argues it was not until 8/21/2007 that Dr. Rosen made it patently clear the

applicant's respiratory status and cardiovascular system would be compromised after being moved to a care facility, Care Meridian, and that he would not release applicant from the hospital until a wheelchair was available. It was at that point defendant gave written authorization and the wheelchair arrived on 8/24/2007. He was discharged from Northridge Hospital and sent to Care Meridian on 9/13/2007. Under these circumstances, defendant argues there is no unreasonable delay, and no penalty should attach.

By his answer to the petition for reconsideration, the applicant correctly details why the defendant is incorrect, and why there is substantial evidence to impose the Labor Code section 5814 medical treatment penalty due to the four-month post-Utilization Review certification delay in providing the prescribed wheelchair with tilt, explaining at pages 14-19 of the answer to the petition for reconsideration, as follows:

> "Neither Section 5814(e) nor Section 4610.1 relieve the employer of such liability where it either fails to timely reimburse treatment that it did not authorize or where, after receiving a U.R. approval of a request for medical treatment, the employer unreasonably delays authorization. On 04/26/07 U.R. certified as medically necessary and appropriate the purchase of a motorized wheelchair with tilt. (02/03/11 Minutes, 10; Exh. "52"). The chair was not delivered to Northridge Hospital until 08/27/07. (1 McDivitt Dep., 74: 17-75:7).
>
> McDivitt claimed the delay was occasioned first by the need to determine whether the chair could be rented; by negotiations with two different providers; because, when the selected provider, Medical Services Co. ('MS"), performed the evaluation, it was determined that additional accessories were needed. McDivitt said further delay was encountered because these had to be submitted to Dr. Rosen so that he could address necessity in a subsequent report. She said Charles had a wheelchair at Northridge but wasn't using it because he was non-compliant and refused to get out of bed. (Id. at 75:9-77:6).
>
> To her recollection, McDivitt said, the delay was not caused by her failure to provide a signed authorization. (Id. at 77:9).

When confronted with the 07/09/07 & 08/22/07 case management reports from Suzanne Crane, RN, which recited that the "evaluation and quote are completed with the signed authorization pending" (Exh. "51"), McDivitt testified that Ms. Crane was "not in the loop" after the matter had been assigned to MS. (1 McDivitt Dep., 77:10-78:21).

The employer falsely states that Charles "intentionally left out that Mr. Romano, while in Northridge Hospital, had the availability of a wheelchair." (Pet. for Recons., 19).

The motorized wheelchair with a tilt was needed because ***the hospital's wheelchair was not suitable for Charles' needs***. (Crane Dep., 46). Charles needed a tilt because he had to be able to shift his body weight back and forth to prevent ulcers on his buttocks. Ms. Crane explained this to McDivitt. (Id. at 21)." (Emphasis added).

. . .

Emails appended to the Crane deposition (02/03/11 Minutes, 17; Exh. "111") reveal that McDivitt was informed on 05/11/07 that "the facility does not have any vendor that would rent a wheelchair." (Recall the 04/26/07 U.R. certified a "purchase")

On 05/16/07 -- 20 days after U.R. approved the "purchase" of a motorized wheelchair with tilt -- McDivitt emailed Ms. Crane, stating the "UR approval is on a motorized chair." She demanded "an explanation for all charges over standard." She asked who made "the determination of the features of this chair."

Ms. Crane's email reply reads: "The certification is for a motorized 'wheelchair with tilt.' Please note in the certification letter that the reviewing physician stated that 'if the patient qualifies for a power wheelchair . . . additional accessories may be needed. . ."

Ms. Crane's reply email listed specific accessories, adding that most items were standard; that "the physical therapist made the recommendations," but that she could "ask Dr. Rosen to write something to support" the additional options.

Ms. Crane secured a quote from a vendor on the employer's MPN who had been recommended by Northridge Hospital. It was ready and required only an authorization. McDivitt insisted on using a second provider, which mean starting the process all over again. (Id., 25)

Exhibit "53-B" (02/03/11 Minutes, 10) is a detailed 05/16/07 quote from Experia Healthcare for a power wheelchair. McDivitt did not say this quote was deficient. She never explained why she insisted on obtaining a second quote from a second vendor. Two months post-U.R. certification, an 06/27/07 email reflects Dr. Rosen issued a letter on 05/18/07 supporting the accessories. It reflects Dr. Rosen issued a second letter on

06/22/07 and confirms McDivitt's preference to use the second vendor, MSC.

Ms. Crane, whose role as a nurse case manager required her to coordinate between physicians, vendors and claims, testified that she was very much in the loop. (Crane Dep., 26:22-27:9).

Emails commencing 07/05/07 substantiate that coordination. Crane told McDivitt that MSC "will not start to actually order the wheelchair until they have written authorization from you." Another 07/05/07 email noted that "National Seating and Mobility is sending the evaluation. . . . Please contact her with your written authorization. They will need to have it directly from you before they can start processing the wheelchair for the patient."

Ms. Crane testified that, at a minimum, by 07/19/07 everything was in place and that the only thing that was holding up receipt of the wheelchair was the lack of the requested written authorization. (Crane Depo, 22:21-23:4; 30:26). McDivitt did not provide that written authorization until after Ms. Crane informed her that Dr. Rosen would not discharge Charles from Northridge Hospital until he received the wheelchair! (Id., at 23:5-14; *see also* 08/21/07 email noting that, without the wheelchair, Charles' respiratory status and cardiovascular system would be compromised after he is moved to Care Meridian and that "Dr. Rosen would not release he patient until the wheelchair is available for the patient.")

Thus, McDivitt, knowing full well the vital, life-sustaining need for a wheelchair with a tilt *while in the hospital*, first caused an unnecessary delay by insisting on looking for a rental. She received an initial detailed quote on 05/16/07, an 05/18/07 report from Dr. Rosen further explaining the need for accessories but pulled the rug out from the entire process by insisting on a second vendor.

Despite a specific 07/05/07 request, McDivitt failed to provide a written authorization until after being informed on 08/21/07 that Dr. Rosen will not discharge the patient without the wheelchair. The wheelchair did not arrive until 08/24/07. Interim emails reflect McDivitt's real concern was how quickly Charles could be discharged from the hospital.

. . . The employer failed to meet its burden of proving the four month delay was occasioned by "genuine doubt" (*Kerley, supra*) or that it could be deemed reasonable under the totality of the circumstances. *Stuart, supra.*

The WCJ, by finding the facts and argument recited in applicant's briefs "more persuasive and convincing," factually accepted Ms. Crane's

testimony as more credible. That credibility determination is entitled to "great weight." *Lamb vs. WCAB* (1974) 11 Cal.3d 274, 39 CCC 310, 314." [Emphasis in original.]"

For the reasons stated above, there is substantial evidence to support the findings made the defendant unreasonably delayed medical treatment in the form of motorized wheelchair with tilt.

Bi-PaP Machine

The defendant contends it did not unreasonably delay authorization of the Bi-PaP machine because when it first received a request for authorization of the machine by prescription dated 8/27/2007, the claims adjuster sent an email to the medical provider denying authorization because "the medical documentation submitted to date suggest that the sleep apnea is a pre-existing condition and to date there is no medical documentation to medically substantiate that his sleep apnea is residual of the work injury." (Exhibit 92). The defendant contends the claims adjuster understood there was no medical evidence establishing a need to treat applicant's sleep apnea on an industrial basis. It notes the Nurse Case Manager, Suzanne Crane, communicated to the adjuster in approximately February or March of 2007 the physicians at Northridge Hospital had determined the applicant was suffering from sleep apnea early on and that the nature of the paralysis was such that his muscles could not aid his breathing. (Crane Dep., pp. 13-14, 32). It argues the defendant did not receive a request for authorization until 8/27/2007, and when the Nurse Case Manager later explained to the claims adjuster he could not be discharged from the hospital without the device the BiPaP machine was authorized and provided on or about 9/11/2007 (Crane Dep., p. 33).

In response to the defendant's contentions, the applicant notes the Section 5814 penalty attaches because the lay adjuster, contrary to Labor Code section 4610(e), took it upon herself to deny authorization on 8/27/2007. The claims adjuster received the

request for authorization on 8/27/2007 requesting confirmation within 48 hours. The adjuster having received the prescription requesting authorization, failed to refer it to utilization review, and instead submitted the above-noted email to the provider. Section 4610(e) provides "No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure or relieve." The applicant by his answer to the petition for reconsideration at pages 20-21 further correctly explains why defendant's contention there was no unreasonable delay is not supported by the evidence as follows:

> "At the time she issued the denial, McDivitt knew this court found the injury had resulted in a paralysis. (1 McDivitt Dep., 18:10-12). She knew that the finding of an injury to the pulmonary system meant "the lungs;" which, in turn, affects the ability to breathe. (Id., at 19:10-16). McDivitt knew Dr. Rosen said in an 06/05/07 report that Charles' medical condition included orthostatic hypotension and sleep apnea that was so severe that Charles tends to stop breathing. (Id., at 56:13-19; see also Exh. "90-B").
>
> McDivitt knew that liability for medical care is not apportioned and that, consistent with *Braewood Convalescent Hosp. vs. WCB (Bolton)* 1983) 34 Cal.4th 159, 48 CCC 567, even if the sleep apnea were entirely non-industrial, the employer would be obligated to furnish treatment if it were necessary to relieve the effects of the industrial injury. (Id., 22:18-23:25).
>
> Susan Crane, R.N. testified the doctors at Northridge Hospital determined early on that Charles was suffering from sleep apnea; that the nature of the paralysis was such that his muscles could not aid his breathing; that this could be fatal. Ms. Crane communicated all this to McDivitt in Feb./March 2007. (Crane Dep. at 13:13-14:10; 31:23-32:9).
>
> With the knowledge that her decision to deny a BiPap could prove fatal and that, based on an extensive work-up at Northridge Hospital, a BiPap was needed to cure or relieve, it would have been unreasonable for McDivitt to delay authorization upon the ground that Charles had a pre-existing sleep apnea even for the maximum of 72 hours permitted by

Labor Code §4610(g)(2) for a U.R., let alone the 15-16 days actually occasioned by this specious denial by a lay claims examiner.

McDivitt relented not on the basis of evidence of medical necessity, which was already abundant on 08/27/07, but on the basis of venality. She authorized the Bi-Pap only after Dr. Rosen said he would not discharge Charles unless the Bi-Pap was provided. (Crane Depo., 33:10-22)."

For the reasons stated above, there is substantial evidence to support the findings made the defendant unreasonably delayed medical treatment in the form of motorized wheelchair with tilt.

Hospitalization at Community Memorial Hospital

The defendant contends it did not unreasonable delay medical treatment in the form of hospitalization at Community Memorial Hospital. It argues a bill in the sum of $129,581.07 for the hospitalization (where the applicant was last hospitalized at the time of his death) was submitted to defense counsel with a demand for payment on 6/8/2008. It notes based upon the applicant's revised and amended petition for award enforcement filed on 9/5/2008 the applicant's attorney was advised by a representative of Community Memorial Hospital the hospital had made a verbal request for authorization to treat the applicant upon his admission in April of 2008. The defendant made payment to the hospital on 10/24/2008. It cites the testimony of Theresa McDivitt wherein she noted she had only one conversation with Community Memorial Hospital and at that time she had been notified by Monica Bender, a nurse case manager, the applicant was on his way to the hospital with an unknown illness, that she was told he was noncompliant, refusing medical care and they did not know what was wrong, and that during her conversation with Monica Bender, Ms. Bender had no clue as to why he was being hospitalized. It further argues the adjuster early on in her deposition testified "she did not provide or decline authorization to these entities."

By his answer to the petition for reconsideration at page 21, the applicant argues the four and one-half month delay in payment of the Community Memorial Hospital bill is patently unreasonable. Applicant notes the adjuster admitted she did not authorize the hospitalization. (1 McDivitt Dep., 25:7-9). Although Section 5814(e) provides no unreasonable delay in the provision of medical treatment can be found if the only dispute concerns payment of a billing submitted by a physician or medical provider in Section 4603.2, said exemption from the penalty statute only attaches "when the treatment has been authorized by the employer in a timely manner." Here, the adjuster admits no authorization was given. The applicant also refutes the defendant's contention the 4 ½ month delay in making payment to the hospital was reasonable because defendant had "no clue" as to what was wrong with the applicant and why he was hospitalized, as explained at pages 22-23 of the answer:

> "The employer's claim that the delay was occasioned by the fact that it had "no clue" as to why Charles was hospitalized at CMH (Pet, for Recons., 6-7) is not only belied by the fact that McDivitt delegated the task of ascertaining the course and scope of Charles' treatment at CMH to the second nurse case manager she had selected, Monica Bender, but by the fact that Bender told McDivitt the CMH physicians diagnosed Charles' pneumonia to be "out of control." (1 McDivitt Dep., 90:19-91:8). In fact, McDivitt testified:
>
> 'Q. Did you inquire as to whether the treatment being furnished was related to your obligation?
>
> A. I believed it was." Id., at 93:1-3.'
>
> Worse, McDivitt revealed by her testimony (Id., at 84:12-97:3) the mistaken, and appalling, belief that the employer could evade liability through a see-no-evil, hear-no-evil, passive approach to claims administration in a catastrophic, life-and-death case.
>
> There can be no question but that a simple inquiry would have established that Charles' CMH hospitalization was work-related. (See, e.g., 04/124/08 T. Snow, M.D. rpt. whose diagnosis included MRSA pneumonia, hypoxia and paraplegia). (2/13/11 Minutes, 16; Exh. "100").

Instead of contacting the hospital's administrators, advising them of the employer's obligation to furnish and authorize necessary treatment and of the treating physicians' reporting responsibilities (8 C.C.R. §9785), she held back, not even responding to the 06/08/08 demand for payment (02/03/11 Minutes, Exh. "84-A") until 10/24/08 when payment was tendered during the pendency of these award enforcement proceedings.

This is a far cry from the affirmative obligations imposed by Labor Code §4600(a).

"***Section 4600 requires more than a passive willingness on the part of the employer to respond to a demand or request for medical aid.*** [Citation]. ***This section requires some degree of active effort to bring to the injured employee necessary relief.*** [Citation]." *Braewood Convalescent Hosp. vs. WCAB (Bolton)* 1983) 34 Cal.4th 159, 48 CCC 567, 569 (Emphasis added).

As explained in *Aliano vs. WCAB* (1979) 100 Cal.App.3d 341, 44 CCC 1156, 1171-1172, after noting that an employer has a "duty to ***adequately and fairly*** investigate [an applicant's] claim," added "'an employer has both the right and ***duty to investigate the facts*** in order to determine his liability . . . but he must act with expedition in order to comply with the statutory provisions . . . which require that ***he take the initiative in providing benefits***. [Citation]." (Emphasis in orig.).

The employer's abdication of its affirmative responsibilities is a far cry from "genuine doubt." *Kerley, supra.*"

For the reasons stated above, there is substantial evidence to support the findings made the defendant unreasonably delayed medical treatment in the form of hospitalization at Community Memorial Hospital.

Community Imaging Medical Group bill

The defendant contends the Community Imaging bill in the sum of $242 was served by the applicant on 6/8/2008 (Exh. 86) and the claims adjuster testified she was uncertain whether the bill had been paid at the time of her deposition, and that it would have been paid unless there was a need for additional documentation. It argues there is no evidence that the necessary documentation accompanied the bill, hence no penalty should attach under Section 5814.

In response to the defendant's contention, the applicant notes the employer was served with the Community Imaging Medical Group bill dated 5/14/2008 in the sum of $242 (Exh., 86B) which would have been in conjunction with his hospitalization at Community Memorial Hospital which the employer failed to authorize as noted above. The statement dated 5/14/2008 shows the charges are for chest-x rays performed on 5/7/08, 5/8/08 & 5/13/08, and CT head/brain w/o dye performed on 5/8/08 at Community Memorial Hospital. As noted by the applicant since the defendant failed to authorize the hospitalization and related diagnostic testing, the exception under Section 5814(e) does not apply, and there is no evidence the defendant ever paid or objected to the bill. As with the bill of Community Memorial Hospital bill, the defendant had a duty to adequately and fairly investigate the Community Imaging Medical Group bill dated 5/14/2008 and duty to investigate the facts in order to determine its liability and act with expedition in order to comply with the statutory provisions which require defendant take the initiative in providing benefits due. Confessing ignorance about the bill and taking no action as to its payment following receipt of said bill in June of 2008 is not evidence of genuine medical or legal doubt.

For the reasons stated above, there is substantial evidence to support the findings made the defendant unreasonably delayed medical treatment in the form of authorization and payment of Community Imaging bill.

HMS/Dept. of Health Services Reimbursement

The defendant contends the delay in reimbursement to HMS/Department of Health Services is not unreasonable. It notes on 10/25/2007 defendant was served with the lien for Medi-Cal's payments for the self-procured treatment at VCMC, various pharmacies and SJRMC in the total sum of $275,439.14. It notes the claims adjuster

testified the defendant made payment to the lien claimant on 7/23/2008 in the sum of $200,000 which was a settlement amount. (1 McDivitt, Dep., p. 134).

The applicant by his answer to the petition for reconsideration at pages 24-25 correctly observes by the Amended Findings and Award of 10/25/2006 it was adjudicated the applicant's self-procured 11/7/3005 admission and lengthy stay at VCMC until 7/1/2006 was industrially-related, and that the WCJ found the employer "failed to render medical treatment when necessary" and directed the defendant to adjust the lien. Applicant correctly notes the *defendant failed to adjust or pay a portion of the lien until 7/23/2008* when it made payment in the sum of $200,000 during the pendency of these pending penalty proceedings. Because the defendant failed to authorize the VCMC hospitalization, Section 5814(e) is not applicable. As further explained by applicant:

> "*Neel v. WCAB* (1988) 67 Cal.Apo.4th 847, 63 CCC 1344 is on all fours. In *Neel*, the parties entered a C & R, which included a provision that the employer was to adjust the balance of outstanding medical bills. Although the employer eventually paid a pharmacy, a Labor Code §5814 penalty was assessed because the one year delay between the date of the order approving the C & R and the date of payment was unreasonable.
>
> Here the payment came more than one year and seven months after this court denied reconsideration of an F & A which directed the employer to adjust the self-procured treatment expenses. The employer admits it received a 10/25/07 lien from HMS/Dept. of Health Service. It adds that on 11/07/07 "McDivitt requested medical records and reports to review for payment." (Pet. For Recons., 7).
>
> But on 11/07/07 the employer already had those records. The VCMC records were admitted into evidence during the original proceedings and were discussed at length by WCJ Huang in his 10/25/06 opinion on the decision. McDivitt did not create a genuine doubt by requesting another set of records.
>
> The employer failed to meet its burden of proving that the significant delay was occasioned either by genuine doubt (*Kerley, supra.*) or that the extraordinary delay was reasonable under the totality of the circumstances. *Stuart, supra.*"

For the reasons stated above, there is substantial evidence to support the findings made the defendant unreasonably delayed medical treatment in the form of reimbursement to HMS/Department of Health Services lien.

Venous Doppler Studies and Psych Consult

The defendant contends it did not unreasonably delay medical treatment in the form of venous/Doppler studies and psychiatric consultation. It argues defendants were served with prescriptions for venous/Doppler studies and for a psychiatric consult on 11/6/2007. (Exh. 95). Relying on the testimony of the claims adjuster it contends defendant did not submit this to UR as there was no dispute, and promptly authorized the studies. (1 McDivitt depo., 118-120). It argues the studies were authorized in December of 2007, and the applicant obtained a medical-legal consult confirming the need for psychiatric treatment. The bill for the consult is $4,625 notes defendant. The evidence demonstrates to the contrary the defendant did unreasonably delay those treatment benefits as correctly noted by the applicant at pages 25-27 in the answer to the petition for reconsideration, explaining as follows:

> "On 10/30/07 Dr. Feiss wrote a prescription for a psychiatric consultation. The prescription noted Charles was suffering from suicidal ideation. (02/03/11 Minutes, 15; Exh. "95-C"). Both the psychiatric consult prescription and a prescription for Doppler Studies were served on the employer on 11/06/07 via FAX and first class mail. (Exh. "95-A"). The letter/fax proposed Warren Procci, M.D. as an AME and stated that if a QME consult was scheduled, the employer "must authorize transportation."
>
> Although McDivitt believed that she would have authorized the Doppler study "relatively quick" via FAX (1 McDivitt Dep., 118:5-20), the FAX was not produced at her second, 07/09/09 deposition (02/03/11 Minutes, 16; Exh. "110-A) despite a notice to produce Exh. "110-B") and was not listed as an exhibit at the ensuing MSC. If the employer had submitted timely written authorization, the FAX would have been in the employer's possession long before the MSC. The WCJ appropriately

denied the employer's request to reopen the record, for to rule otherwise would amount to an abuse of discretion. Labor Code §5502(e)(3); *San Bernardino Comm. Hosp. vs. WCAB (McKernan)* (1999) 74 Cal.App.4th 928, 64 CCC 986.

There is no competent evidence that McDivitt authorized a psychiatric consult. When asked, McDivitt said she did not recall; that she "imagined" she did. (1 McDivitt Dep., 118:21-24). If a faxed authorization were sent, the employer stipulated it would produce a copy of the same. (Id., at 119:6-22). The employer neither produced nor offered such a fax in evidence.

The employer now claims it was entitled delay authorization for psychiatric care because this court had not expressly found a psychiatric injury as part of the sequelae of the MRSA infection. (Pet. for Recons., 25).

McDivitt testified she could think of no reason why she did not authorize it. (1 McDivitt Dep., 120:9-11). Indeed, she conceded Charles would need prescribed psychiatric care as part of the management of his catastrophic injury. (2 McDivitt Dep., 202:22-203:1). (02/13/11 Minutes, 16; Exh. "110-A").

McDivitt's concession was consistent with the rationale of *Bolton, supra*, with Dr. Rosen's testimony (Rosen Dep., 34:25-37:14) (02/03/11 Minutes, Exh. "45") and with the 05/02/07 evaluation by psychiatrist Walter Jacobson, M.D. at Northridge Hospital (Exh. "35")."

For the reasons stated above, there is substantial evidence to support the findings made the defendant unreasonably delayed medical treatment in the form of venous/Doppler studies and psychiatric consultation.

Reimbursement for Wheelchair-Accessible Van

The defendant contends there is no unreasonable delay in reimbursement of wheelchair accessible van. It notes defendant was served on 1/2/2008 with a prescription for a wheelchair accessible van "for therapeutic outings, attending church and community re-entry." (Minutes of Hearing 1/2/08). Defendant notes it was subsequently served with a receipt for $39,124.03 for purchase of the van. (Exh. 39). The defendant's response to having been served with the receipt at the hearing held on 1/2/2008 was that "the expense was self-procured, abusive, exceeded the prescription

and unauthorized." It notes the deposition testimony of Sidney Ronald Freeman dated 3/3/2010, at exhibit 3 appended to the deposition, reveals "the van was equipped with a remote controlled 22" TV monitor, a remote controlled DVD rear system, game ports, custom grill, exterior graphics, and a power bi-fold rear sofa." It further notes nowhere on the exhibit 3 is there indication any lift was included. It argues none of the luxury items were mandated by the medical evidence. It argues there was clear abuse by the applicant and/or through his attorney.

In response to defendant's contentions, applicant persuasively argues as follows at pages 27-30 of the answer:

> "Charles right to self-procure medical transportation in the form of a wheelchair accessible van arose long before Dr. Feiss issued his 12/19/07 prescription for therapeutic outings, attending church and community re-entry. (02/03/11 Minutes, 10-11; Exh. "59-B") It arose the moment the employer neglected to furnish that level of transportation that was necessary to cure or relieve. Labor Code §4600(a); *Bolton, supra; Aliano, supra.*
>
> The medical record, the testimony of Ms. Crane and Mr. Freeman, and even McDivitt's concessions, establish that Charles, from the time he was first hospitalized until the date of his death on 05/02/08, was bedridden, incapable of transporting himself. Charles suffered from so severe and complete a paralysis that every time he was to be transported, two people had to first transfer the bedridden Charles, whose weight per Freeman swelled to between 280 and 330 lbs. (Freeman Dep., 14:6-17), from his bed to a wheelchair. Charles required not only the use of a wheelchair accessible van but two people to insure that Charles did not roll off his chair. (Id. at 24:6-10). At Northridge Hospital, Charles had immediate access to a broad array of multi-modality treatment, including two specialists in physical medicine and rehabilitation, plus specialists in infectious disease, cardiology, podiatry, orthopaedic medicine, psychiatry and a nurse case manager. That access was vital to Charles' very survival.
>
> On 09/13/07 Charles was transferred to Care Meridian, an outpatient nursing facility. The employer knew that Care Meridian employed a single, staff physician, Dr. Feiss and acknowledged that it was

unaware of any other physician who would be responsible for his care. (1 McDivitt Dep. 80:12-22; 84:7-11).

McDivitt took the position that her only responsibility was to passively sit back and await specific requests. (See, 1 McDivitt Dep., 122:14-124:18). She did not furnish transportation because it "was provided by Care Meridian." (Id., at 122:14-123:23). Care Meridian, she baldly asserted, "stated in their reports that they took him for outings." (Id., at 124:10-12).

The employer did not offer a single report from Care Meridian that would substantiate that claim.

Mr. Freeman's testimony revealed that McDivitt had no clue about what type of vital, life-sustaining transportation, if any, was available to Charles at Care Meridian. Freeman, who visited Charles 5 days/week while Charles was at Care Meridian, described his living arrangements: A room 12 by 15, bed and TV. The bed was very uncomfortable. Charles had neck problems and was in constant agony. ***Care Meridian never furnished transportation for Charles!*** (Freeman Dep., 18:1-21).

Care Meridian occasionally arranged for public transportation but only for local appointments, and when they did, they asked Freeman to go with Charles because they did not want Charles to go alone and there was nobody from Care Meridian who could go with him. There were eight patients at the facility, which ordinarily did not have sufficient staff to accompany Charles. (Id. at 21:3-24). Public transportation was not available for special appointments or anywhere else, so Freeman had to rent a vehicle. (Id. at 19:2-4).

Freeman testified that "Dr. Feiss told [him] that Charles needed to get a change of scenery; otherwise, depression is going to kill him." (Id., at 19:10-14). That testimony is not only supported by Dr. Feiss' prescription but by Dr. Rosen's testimony about the devastating emotional impact of Charles' impoverished existence (Rosen Dep., 34:25-37:18) and by Warren Procci, M.D., the psychiatrist who examined Charles on the same day Dr. Feiss wrote the van prescription, wherein Dr. Procci recorded Charles' "feelings of severe depression, hopelessness and powerlessness" plus "passive suicidal ideation." (12/19/07 Procci rpt., 11). (02/03/11 Minutes, 9; Exh. "48").

The employer's argument that "the prescription for the van was not medical treatment" (Pet. for Recons., 26) is nothing short of shocking!

Avalon Bay Foods vs. WAB (Moore) (1998) 18 Cal.4th 1165, 63 CCC 902, 909 not only held that medical transportation expenses are medical treatment within the meaning of Labor Code §4600, but that such transportation is a "necessary means to the end of ensuring prompt

medical treatment." Injured employees who furnish their own transportation are self-providers" of medical treatment who are entitled to reimbursement of transportation expenses within the time provided for by Labor Code §4603.2. (*Moore, supra,* 63 CCC at 912-913).

Although SB-899 superseded the holding in *Moore* that an employer is subject to a 10% penalty that attaches to the entire class of benefits by limiting the remedy to no more than 25% of the amount actually delayed (Labor Code §5814 (a)) , it did not alter the determination in Moore that medical transportation is medical treatment." [Emphasis in original.]

The applicant also correctly argues the panel decision in *Bishop v. Workers' Comp. Appeals Bd.* (2011) 76 Cal. Comp. Cases 1192 (writ denied), cited by the defendant is distinguishable from the case at bar. Unlike the applicant in *Bishop*, the evidence here shows the applicant's "need for medical transportation entailing both a wheelchair accessible van and attendant in order to receive vital medical care was essential to his very survival" given the catastrophic nature of his resulting injury. The defendant furthermore never submitted the prescription issued by Dr. Feiss to utilization review for retroactive review nor did it object to the expense in accordance with Labor Code section 4603.2. In making findings as to the reasonable value of the self-procured wheelchair accessible van, the undersigned WCJ was mindful of the defendant's objection as to "luxury" items, and reduced the amount sought by more than $4,000 awarding the applicant the sum of $35,000. And as further noted by applicant in the answer, to date the defendant has not reimbursed any amount as to the cost of the van.

For the reasons stated above, there is substantial evidence to support the findings made the defendant unreasonably delayed reimbursement of wheel chair accessible van, the reasonable value of said van being the sum of $35,000.

Nurse Case Manager at Discharge from Northridge Hospital in 9/2007

The defendant contends it did not unreasonably delay appointment of a nurse case manager upon applicant's discharge from Northridge Hospital in September of

2007. It contends the services of Nurse Case Manager, Suzanne Crane, who was the nurse case manager beginning in January of 2007 and served as such throughout the entire time the applicant was an in-patient at Northridge Hospital, was not terminated at the request of the claims examiner. It argues when the applicant was transferred from Northridge Hospital to Care Meridian on 9/13/2007, Nurse Case Manager Crane closed her file. Dr. Feiss was the sole physician at Care Meridian and became the applicant's primary treating physician until his hospitalization at Community Memorial Hospital in late April of 2008. When deposed on 12/6/2007, Dr. Rosen testified the applicant should have the assistance of a nurse case manager with knowledge of spinal cord injuries (Exh. 45, pp. 32-33), and on 1/4/2008 Dr. Feiss wrote a prescription for one which was served on 1/9/2008. It requested Nurse Case Manager Crane be reassigned to the case, and a NCM was reassigned on 2/7/2008. The defendant argues the claims adjuster denies she terminated Nurse Case Manager Crane's services, and notes the adjuster testified it was her understanding nurse case manager services would be furnished by Care Meridian. (1 McDivitt, 79:1-22). It contends there is no substantial evidence to support applicant's claim for penalty.

In response, the applicant persuasively argues there is substantial evidence, as explained at pages 32-35 of the answer to the petition for reconsideration, as follows:

> "Neither party disputes that, at the time Charles was a patient at Northridge Hospital and had immediate access to a wide array of physicians, Susan Crane, R.N. acted as a nurse case manager. Neither party disputes that Ms. Crane's services terminated on 9/13/07. McDivitt denied she "terminated" Ms. Crane's services, claiming instead that Ms. Crane "closed her file" after Ms. Crane told McDivitt that nurse case management services would be furnished by Care Meridian. (1 Mcivitt Dep., 79:11-20). Ms. Crane, who is employed by CorVel, testified that her case management services ended because the employer did not want to work with her company anymore. (Crane Dep., 40:15-41:12). Crane denied telling McDivitt that Charles no longer required the services of a nurse

case manager or that Brandy, at Care Meridian, would provide nurse case management services. (Id., at 41:19-22) Ms. Crane testified that Charles' medical care needs could not be handled by a single, in-house physician; that Dr. Rosen had conveyed the need to be given access to multiple physicians. (Id., at 49:3-15).

> "Q. And so the idea of simply sticking him in there and having one doctor taking care of him would be out of the question; is that correct?
>
> A. That's right." (Id., 49:16-19).

Ms. Crane, who has been both a registered nurse and certified case manager since 1984 (Id. at 8:8-9:1) noted that the role of a nurse case manager is to attend appointments and coordinate treatment in multi-modality cases to avoid duplication, insure that the patient is not prescribed conflicting medications that may be medically contraindicated and to insure patient safety by coordinating care between the patient, the multiple treating physicians and claims. (Id. at 9:13-10:1).

Dr. Rosen testified on 12/07/07 that Charles required the assistance of a nurse case manager with knowledge of spinal cord injuries. (Rosen Dep., pp. 32:13-33:20).

The responsibility of a facility manager differs from that of a nurse case manager. The facility manager coordinates care within the facility, such as when nurses come in. (Id. at 39:4-11). A facility manager does not even have to be a nurse. (Id., 39:12-21).

Ms. Crane rated Charles as a 10 on a scale of one to ten as being the most severe and complicated case she has handled. (Id. at 11:17-12:2). Charles' need for a nurse case manager was much greater after he was transferred from Northridge Hospital to Care Meridian. (Id. at 40:4-5).

On 01/02/08 a stipulated minute order issued providing that the employer "authorizes and will pay for all prescriptions for medical evaluation, diagnostic testing or treatment from Dr. Feiss pending receipt of rebuttal report from Dr. O'Neill . . ."

On 01/04/08 Dr. Feiss wrote a prescription for a nurse case manager. The prescription was served by first class mail and FAX transmittal on 01/06/08. (02/03/11 Minutes, 11; Exhs. "61-A" & "61-B").

On 01/15/08 Applicant demanded that Ms. Crane be re-authorized to act as a nurse case manager. (Exh. "62").

In an 01/23/08 letter, the employer's counsel asserted that he "cannot see how this recommendation for a nurse case manager was in any way contemplated by Judge Treadwell's order for treatment, consultation and diagnostic testing." (Exh. "64").

In an 01/28/08 letter to WCJ Treadwell, Charles, citing *Hodgman vs. WCAB* (2007) 155 Cal.App.4th 155, 72 CCC 1202, argued that nurse case management services were clearly a form of medical treatment contemplated by the 01/02/08 order and that the refusal to authorize nurse case management services pursuant to Dr. Feiss's 01/04/08 prescription was not merely unreasonable but contemptuous. (Exh. "65").

McDivitt concedes the prescription for nurse case management services was a prescription for medical treatment. (1 McDivitt Dep. 109:17-25).

A new nurse case manager was not appointed until 02/07/08 (Id. at pp. 115:16-116:) and then only after the employer's QME, Dr. O'Neill, issued an 01/25/08 report (02/03/11 Minutes, 2-3; Marked as Exh. "A-4" for ID only because of objection pertaining to the wheelchair accessible van). Charles did not object to the segment of the report in which Dr. O'Neill stated: "I am surprised that Mr. Romano doesn't already have a nurse case manager when one considers the degree of complexity of his illness and its aftermath. He certainly needs someone who can coordinate all of the medical needs he has . . ." (01/25/08 O'Neill rpt., p. 2)

The WCJ was entitled to find Ms. Crane's testimony more credible than McDivitt's. Whether the employer terminated Ms. Crane's services or Ms. Crane quit is of no moment. The fact is that, as of 09/13/07, when Charles' need for a nurse case manager and adequate transportation to insure access was acute, nurse case management services ended.

Dr. Rosen's 12/07/07 testimony reveals that had the employer failed to fulfill its "duty to investigate the facts in order to determine [its] liability" (*Aluano, supra*). It could have ascertained the need for a nurse case manager before Charles was left to vegetate at Care Meridian in Sept. 2007. Certainly, by 12/07/07 the employer, through counsel, knew of the need for a nurse case manager and the life threatening consequences of lack of access to multi-modality treatment, yet even with the 01/02/08 order and 01/04/08 prescription from Dr. Feiss, it refused to provide one.

Instead of complaining about the penalty award, the employer should be grateful for the WCJ's charitable decision not sanction its wilful violation of the 01/02/08 order. Labor Code §5813; 8 C.C.R. §10561(b)(4)."

For the reasons stated above, there is substantial evidence to support the findings made the defendant unreasonably delayed appointment of a nurse case manager upon applicant's discharge from Northridge Hospital in September of 2007.

St. John's Regional Medical Center

The defendant contends there is no evidence of unreasonable delay in authorizing treatment at SJRMC. With respect to the second hospitalization at SJRMC, it argues the applicant was noted to have sustained a second myocardial infarction on 9/3/2006 due to "triple vessel coronary artery disease." It notes the discharge diagnosis on 9/7/2006 included "acute coronary syndrome with suspected acute myocardial infarction." It further notes none of the hospitalizations at SJRMC received prior authorization. (1 McDivitt Dep., 24:4-25:9).

In response, the applicant persuasively notes there is substantial evidence to support the penalty imposed as noted at pages 36-37 of the answer to the petition for reconsideration, as follows:

> "This involves unauthorized, self-procured treatment that falls within WCJ Huang's 10/25/06 directive to adjust. Liability is not affected by Labor Code §5814(e).
>
> Upon his release from his more than seven month in-patient stay at VCMC, Charles self-procured treatment at an attendant care facility, Country Villa Oxnard Manor. The inadequacy of treatment offered by that facility was underscored by Mr. Freeman who received "an emergency call from Charles saying he's very ill." Freeman entered Charles' room. Freeman found "his Foley catheter bag was full of blood . . ." Country Villa personnel had failed to call 9/11, stating, "We can't deal with him" and "they won't come."
>
> Mr. Freeman called 9/11. Charles was transported by ambulance to St. John's Regional Medical Center ("SJRMC") where physicians found "a horrible infection in his bladder." (Freeman Dep., 11:20-12:25).
>
> Charles was hospitalized at SJRMC on 09/02/06 for a myocardia infarction. The SJRMC records reveal that his clinical course was complicated by ongoing infections and paraplegia, which made him a poor surgical candidate. He was discharged on 09/07/06. (Exhs. "36"-"44"). (02/03/11 Minutes, p. 8).
>
> Charles was again hospitalized at SJRMC during the period 11/22/06 to 11/25/06 "for evaluation of hypotension and possibly UTI. His cultures were positive for MRSA, in urine, small abdominal wound

and blood." (11/26/07 Discharge Summary of J. Allen, M.D. , Exh. "44"). (02/03/11 Minutes, 9).

An 05/08/07 demand letter (Exh. "68-A"), an 04/20/07 SJRMC billing (Exh. "68-B"), an 08/21/08 SJRMC letter with supplemental documents (Exh. "69-A") and an 11/20/07 SJRMC lien with supporting documents (Exh. "69-B") were admitted into evidence. (02/03/11 Minutes, 11-12).

The SJRMC records and testimony of Dr. Rosen demonstrated that these two SJRMC hospitalizations were for conditions found by this court to be industrial. At her 03/03/09 deposition, McDivitt admitted she had no recollection of any effort to either pay or adjust the charges from SJRMC. (1 McDivitt Dep., 126-127)

Neel, supra, is controlling."

For the reasons stated above, there is substantial evidence to support the findings made the defendant unreasonably delayed reimbursement of self-procured treatment from St. John's Regional Medical Center.

Gold Coast Ambulance

The defendant contends it did not receive bills from Gold Coast Ambulance near or close to the time the services were provided, and upon receipt much later they were denied and objected to on 1/9/2008 on the basis there was "a lack of evidence that substantiated the condition for which the applicant was treated related to the industrial injury." (Exh. 79). It argues no penalty should attach. It requests that the record be developed because defendant disputes the timeliness of receipt of said bills.

In response to defendant's contentions, the applicant correctly notes at page 37 of the answer as follows:

"The employer was served with two bills from Gold Coast Ambulance on 04/16/07. (02/13/11 Minutes, 12; Exh. "77-A"). The bills reveal that Goad Coast transported Charles to SJRMC on 11/22/06 (Exh. "77-B") and back from the hospital on 11/25/06 (Exh. "77-C"). Dr. Allen's 11/26/07 discharge summary reflects that Charles was hospitalized from 11/22/06 to 11/25/06 "for evaluation of hypotension and possibly UTI.

His cultures were positive for MRSA, in urine, small abdominal wound and blood." (Exh. "44").

The event was confirmed by Freeman's testimony.

This was part of the self-procured treatment subject to WCJ Huang's 10/25/06 adjustment order. *Neel, supra,* is controlling."

The employer's failure to pay the bills is unreasonable. There is no good cause to develop the record. For the reasons stated above, there is substantial evidence to support the findings made the defendant unreasonably delayed or refused medical treatment in the form of Gold Coast Ambulance transportation expense for services rendered on 11/22/2006 and 11/25/2006.

Reimbursement of Guardian Ad Litem Expenses

The defendant contends there was no unreasonable failure to reimburse the Guardian Ad Litem, Joann Richards, for her expenses that defendant asserts are excessive and unreasonable as she lived out of state, and were unnecessary because the applicant could handle his own affairs, and even when his condition worsened in December of 2007 as compared to January of 2006 when she was appointed GAL, the applicant was able to make a deliberate decision to purchase a van costing nearly $40,000. (Freeman depo., 3/3/10, 30:2-18).

In opposition to defendant's contentions, the applicant by his answer to petition for reconsideration persuasively argues at pages 38-39, there is substantial evidence to support the penalty award, as follows:

"On 01/30/06 WCJ Mark Feldman issued an order appointing Jo Ann Richards as Charles' Guardian ad litem on the basis of a medical opinion from Charles' treating physician at Ventura Community Memorial Hosp. that Charles could not physically manage his personal affairs. The order added: "Timely objection showing good cause voids this order."

No physician has ever offered the opinion that would rebut the determination that, at the time the 01/30/06 order issued, Charles was physically incapable of managing his own personal affairs.

On 06/23/06 Charles' legal counsel caused the employer to be served with a Guardian ad Litem expense records, demanding reimbursement. (02/03/11 Minutes, 5; Exh. "5").

The only timely objection under Labor Code §4603.2 to the documented Guardian ad Litem expenses was whether these were recoverable as a "medical expense." (02/03/11 Minutes 7; Exh. "6"), an objection that is simply at odds with established case law. *Hodgman vs. WCAB* (2007) 155 Cal.App.4th 144, 72 CCC 1202.

With Charles hospitalized, paralyzed and quarantined, a guardian ad litem was needed to handle his personal affairs (see, Freeman Dep., 9:20-11:11) in the same manner that a housekeeper was needed to perform medically contraindicated services in *Smyers vs. WCAB* (1984) 157 Cal.App.3d 36, 49 CCC 454. Although, under *Smyers* and *Hodgman*, Ms. Richards would have been entitled to be reimbursed for the reasonable value of her "services," she limited her request to reimbursement of the out-of-pocket expenses.

On 10/09/07 WCJ Huang granted Charles' petition to vacate the previous order appointing Jo Ann Richards as the Guardian ad Litem, which petition was based on the 08/31/07 medical report of Joel Rosen, M.D. which stated, Mr. Romano at this point is both physically and mentally capable of managing his own affairs. . ." (Emphasis added). *All* of the Guardian ad Litem expenses at issue predated Dr. Rosen's 08/31/07 determination.

The Guardian ad Litem expenses were a form of self procured treatment. WCJ Huang found the employer had neglected to provide treatment. The employer failed to pay or adjust this expense, placing this case squarely in line with *Neel, supra*, not to mention the penalties and attorney's fees that were assessed for unreasonable delay in *Hodgman, supra*.

The employer did not object to the fact that the court had appointed, as Charles Guardian ad Litem, a sister who resided in Arizona at any time prior to the 04/21/10 MSC.

For the employer to step forward years after-the-fact to protest the distance involved after it failed to timely object to WCJ Feldman's 01/30/06 order, entails not just waiver but estoppel. Ms. Richards relied upon that order in incurring the expense."

For the reasons stated above, there is substantial evidence to support the findings made the defendant unreasonably delayed or refused medical treatment in the form of reimbursement to applicant's Guardian Ad Litem, Jo Ann Richards, for expense and

time required to transport and remain with the applicant at medical appointments while serving as Guardian Ad Litem from 1/30/2006 to 10/9/2007.

With respect to defendant's contention it is error not to set aside the stipulation of the parties to utilize deposition testimony in lieu of live testimony, the defendant by its petition for reconsideration argues "live testimony would have enabled defendant to provide rebuttal evidence and clear any bias generated by the deposition of Suzanne Crane." It argues live testimony would have allowed the trier-of-fact to assess the witness' credibility which is crucial to deciding the dispute over authorization for the wheelchair and assignment of a nurse case manager.

There is no merit to the contention the undersigned committed error in holding the parties to their stipulation approved on 1/15/2009 that testimony would be provided in the form of deposition in lieu of live testimony. Both parties were given full opportunity to cross examine all three witnesses, and the sequence of the depositions were arranged by mutual consent as noted by applicant in the answer. As further explained by applicant at pages 40-41 of the answer:

> "Although the order included a provision that the parties could restore the matter directly to the trial calendar, in light of the extensive exhibits, the parties proceeded to a second MSC on 04/21/10 at which the employer failed to object or move to set aside the 01/15/09 trial stipulations.
>
> In an 06/13/10 brief, Charles laid out in detail how the evidence acquired between the date of the stipulation and the 04/21/10 close of discovery demolished McDivitt's credibility.
>
> On 07/30/10 the employer submitted a responsive brief.
>
> On 09/15/10 Charles replied, noting that the employer's 07/30/10 brief had played fast-and-loose with the facts and the law. Charles objected to the employer's eleventh hour effort to raise issues that were not raised at the prior MSC.

Trial resumed on 12/20/10, at which time issues were framed on the record and the matter was ordered continued on the trial calendar to 01/13/11.

On 01/25/11 the employer moved, for the first time, to set aside the stipulation and present McDivitt's live testimony "to rebut any bias that has been generated through the deposition transcript. . . [and because the court] will need to determine the veracity and credibility of . . . witnesses. . ."

In an 01/31/11 reply, at 18, Charles argued that the real reason for the motion to set aside the stipulations was the fact that "the credibility of . . . McDivitt has been demolished both by cross-examination and by rebuttal testimony from Ms. Crane and Mr. Freeman."

The WCJ appropriately denied the motion to set aside a trial stipulation.

Except in a case where a stipulation is "entered into through inadvertence, excusable neglect, fraud, mistake of fact or law, or there has been a change in the underlying conditions that could not have been anticipated. . . [a stipulation is] binding upon the parties." *Robinson vs. WCAB* (1987) 194 Cal.Aop.3d 784, 52 CCC 419, 422-423; see also, *County of Sacramento vs. WCAB (Weatherall)* (2000) 77 Cal.App.4th 1114, 65 CCC 1, 4.

The fact that the employer's counsel may not have anticipated just how devastating cross-examination and rebuttal would be to McDivitt's credibility does not justify setting aside stipulations which were entered by competent counsel in good faith."

For the reasons stated above, there is no good cause to allow defendant to withdraw from the 1/15/2009 trial stipulation to present trial testimony in the form of depositions.

As explained by the appeals board in *Ramirez, supra*, at page 1328, "The overriding consideration in determining what penalty amount to assess should be whether the penalty imposed would serve 'the purposes sought to be accomplished' by section 5814. [citation omitted.] The purposes of section 5814 are both remedial and penal. [citation omitted.] Each of these purposes is 'equally important.' [citation omitted.]" As further explained in *Ramirez, supra*, at page 1329, "As stated by the Supreme Court, a section 5814 penalty 'is designed to help an employee obtain

promptly the cure or relief he is entitled to under the law, and to compel his employer to provide this cure or relief in timely fashion. [citations omitted.]" The appeals board enumerated various factors to be considered in determining the appropriate amount of a section 5814(a) penalty, including among other things, the amount of the payment delayed, length of the delay, whether it was inadvertent and promptly corrected, whether there is a history of delayed payments or instead whether the delay was a solitary instance of human error, whether the employee contributed to the delay.

Here, the evidence is overwhelming that following the initial adjudication of disputed issues regarding the nature and extent of the applicant's industrial injury by WCJ Huang in 2006, and his Amended Findings and Award of 10/25/2006, finding the applicant did suffer industrial injury on 12/20/2003 to the "left shoulder and cervical spine with subsequently industrially related staph infection resulting in a compensable consequence injury to his neck, cardiovascular system, pulmonary system, thoracic spine with resulting paralysis," and his finding the applicant in need of "further medical treatment to cure or relieve from the effects of the injury herein limited to his left shoulder, cervical spine and consequences of his staph infection," and his order the defendant "pay or adjust all reasonable medicals and medical-legal liens of record with the court to retain jurisdiction per stipulation of the parties," there was no doubt the applicant was entitled to the pre- and post-award eleven above-enumerated medical treatment benefits, and the defendant's delay and/or refusal to provide said benefits supports the imposition of the maximum section 5814(a) penalty amount as to each. There is no substantial evidence to support a lesser penalty amount as there is no evidence the delay or refusal was due to inadvertence, human error, realities of doing business, statute or regulation justifying the failure or delay, or that the employee contributed to the delay. The impact on the now deceased injured worker was

substantial causing undue pain and hardship. The imposition of the penalty amount assessed herein serves the purposes sought to be accomplished' by section 5814.

Also reasonable and supported by substantial evidence is the Labor Code section 5814.5 attorney fee allowed framed in terms of a general finding at the hourly rate of $350.00 given the applicant's attorney is an experienced and knowledgeable attorney whose diligent, skilled and successful efforts to hold the defendant accountable for its actions have produced a favorable result on behalf of the now deceased applicant and his Labor Code section 4700 personal representative or heir in enforcing the increased compensation penalty statute as to medical treatment benefits. Defendant's assertions to the contrary are without merit.

Any defect contained in the Opinion on Decision is cured by the herein WCJ's Report and Recommendation on Reconsideration. *Smales v. Workers' Comp. Appeals Bd.* (1980) 45 Cal. Comp. Cases 1026 (writ denied).

RECOMMENDATION

For the reasons stated above, it is respectfully recommended that the petition for reconsideration be DENIED.

Dated: 4/4/2012
Filed and Served by mail on above date on all interested parties on the Official Address Record.
By: Mary Garcia
Mary Garcia

RALPH ZAMUDIO
WORKERS' COMPENSATION JUDGE

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

04-04-2012

OFFICIAL ADDRESS RECORD/PROOF OF SERVICE

Case Number: ADJ1372133/VNO0488219

RE: REPORT OF WCJ ON PETITION FOR RECONSIDERATION

CHARLES ROMANO DECEASED	
RALPHS GROCERY CO	Employer, PO BOX 54143 LOS ANGELES CA 90054
SEDGWICK CLAIMS MANAGEMENT SERVICES	Legacy Insurance Company, P.O. BOX 14450 LEXINGTON KY 40512-4450
ERNEST CANNING THOUSAND OAKS	Law Firm, 2060 E AVENIDA DE LOS ARBOLES STE D 504 THOUSAND OAKS CA 91362
BRADFORD BARTHEL TARZANA	Law Firm, 18801 VENTURA BLVD STE 200 TARZANA CA 91356, E-DOCS@BRADFORDBARTHEL.COM

The Report of WCJ on Petition for Reconsideration served 4/4/2012
By mail on the interested parties as shown on the Official Address Record.

By: Mary Garcia
Mary Garcia