CALIFORNIA
WORKERS' COMPENSATION

- ***10 Important Cases Post SB 899***
- ***New QME Regulations***
- ***Return to Work Issues***

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CATHY CASAZZA v. Workers' Compensation Appeals Board, Petaluma School District, (2007), 72 Cal. Comp. Cas 1657

FACTS OF THE CASE

This case involves Labor Code §4656(c)(1) and the new 2-year TTD rule. In this case an injury occurred on 4/22/2004 on a specific basis, and on a continuous trauma basis from 11/2003 through 4/22/2004. Defendant made its first payment of temporary disability benefits on the case to the applicant on 1/26/2006.

Applicant was a part-time teacher's aide and injury was initially denied, but later went to trial and the WCJ found the injury industrial; Defendant had to pick up benefits as a result. The F&A also found that the Applicant was TTD from the period of 4/23/2004 through 5/19/2006 to the present and continuing. Finally, the WCJ felt that the Applicant would be entitled to 208 weeks of additional benefits to run consecutively. In essence the WCJ ordered two periods of 104 weeks of TTD.

Defendant filed a Petition for Reconsideration, contending that the WCJ exceeded the 2-year rule under Labor Code §4656(c)(1) and that TTD should have been awarded from the time that they were forced to pay back benefits on 4/23/2004.

ISSUES

The main issues presented by this case were whether or not Labor Code §4656(c)(1) allows Defendant to take credit for previous periods of TTD that were paid retroactive as part of the 2-year rule, and whether an Applicant who has filed two separate claims can be entitled to 2 different 104-week periods of TTD under the new law.

LAW

As part of the SB 899 legislation, TTD benefits were limited to a 104-week period under most circumstances. Although there are exceptions to the rule, injuries after 4/19/2004 through 1/1/2008 effectively had only 104 weeks of benefits available. However, as the law was written, Labor Code §4656(c)(1) states specifically that "Aggregate disability payments for a single injury occurring on or after 4/19/2004, causing temporary disability shall not extend for more than 104 compensable weeks within a period of two years from the date of commencement of temporary disability payments."

DECISION

The WCAB on review of the case, upheld the *Hawkins* decision indicating that the date of commencement of temporary disability payments, as suggested in Labor Code §4656(c)(1), clearly indicates that TTD benefits are due from that point on, up to a maximum of 104 weeks. In the instant case Defendant paid benefits for the first time on 1/26/2006, therefore Applicant would be entitled to benefits starting from that point on for 104-week period. The argument that TTD benefits should have been credited beginning the period of time that the F&A found [4/21/2004] was rejected by the Board based on the clear wording of the law.

Secondly, as to the argument that Applicant would be entitled to two periods of 104 weeks running consecutively, given that Applicant filed two separate injuries, the Court felt that the evidence has to support successive periods of TTD in order for Applicant to get more than 104 weeks of benefits, even when filing two separate injuries. The evidence must be looked at closely to see if there is evidence that that there are different periods of disability, that did not run concurrently, and if so, and under those circumstances, it is possible for an Applicant to get more than 104 weeks of benefits when filing two or more injuries. In the instant case however the injury was to the same body parts, and the evidence showed that both injuries caused TTD benefits that began on 4/23/2004 and forward. As a result, the WCAB suggested that the benefit would have run concurrently in the instant case.

PRACTICE POINTERS

First of all, it should be noted that the TTD laws were later readdressed for injuries after 1/1/2008. Under Labor Code §4656(c)(2), injuries after 1/1/2008 allow for aggregate disability payments for a single injury causing temporary disability for 104 compensable weeks within a period of five years from the date of injury. As a result, the commencement of benefit issue is no longer an issue for injuries after 1/1/2008. We have from the date of injury five years to collect 104 weeks for each single injury, and after the *Casazza* decision, it appears that multiple injury filings case result in multiple period of 104 weeks, so long as the evidence suggests that the respective injuries caused different periods of temporary disability.

As a result, for each injury that is filed by an Applicant, the claim should clearly indicate which TTD law would apply, and appropriate benefit limitations should be indicated as such.

Labor Code §4656(c)(2) is much better written, and allows for an additional time period for the Applicant to obtain TTD benefits. The confusion over when benefits were commenced is no longer an issue, and Applicants who make a decision to hold off on invasive surgeries or

extensive treatment cannot hold off on that decision and ponder the issue, rather than rush to go forward with the procedures based on the limitation of TTD.

Please also note that there are still several cases that are litigated over the issue of the exceptions to the rule under Labor Code §4656(c)(3), which include injuries involving hepatitis, amputations and HIV. Please note that Applicant attorneys will usually find exceptions to the rule, which would allow an Applicant to obtain up to 240 compensable weeks of benefits for the period of five years from the date of injury.

***JESUS CERVANTES v. El Aguila Food Products, Inc.*, (2009) 74 Cal. Comp. Cas 1336.**

FACTS OF THE CASE

Applicant sustained back injuries in 1996, 1997 and 1998. In 2003 the Applicant entered into a Stipulated Findings and Award that allowed for future medical care to be open. Applicant began treatment later in 2008 and in that year there was a request for back surgery. The first report was actually issued on 11/4/2008 suggesting that the Applicant may be a surgical candidate. Unfortunately that report did not clearly indicate that they were requesting authorization for surgery. Finally, on 2/25/2009 the treating doctor issued a request via fax for surgery authorization, and at that point Defendant obtained a UR report concluding that the surgery was not medically necessary.

Applicant attorney filed for an Expedited Hearing on the issue of surgery arguing that the Applicant was entitled to surgery because the UR denial was not timely, and that Defendant did not object to the treating doctor's request for surgery, as would be required under the Spinal surgery Second Opinion Law, Labor Code §4062(b). Defendant argued in response that the Applicant was not entitled to surgery because the initial 1/16/2009 report did not clearly suggest a need for surgery, and that the 2/25/2009 fax was the first clearly marked request for surgery, and that the UR denial was timely in response to that request, and finally that Defendant, by issuing a UR denial, placed the burden of proof of the Applicant to then proceed with the second opinion process.

At trial, the WCJ issued a Findings and Award ordering Defendant to provide surgery, believing that the treating doctor's report was reasonable and appropriate, and that the UR report was not persuasive.

Defendant filed a timely Petition for Reconsideration.

ISSUES

At issue is Labor Code §4062(b) Spinal Surgery Second Opinion Law that was enacted as part of SB 899.

LAW

Labor Code §4062(b) states, "The employer may object to a report of the treating physician recommending that spinal surgery be performed within 10 days of the receipt of the report. If the employee is represented by an attorney, the parties shall seek agreement with the other party on a California licensed board-certified or board-eligible orthopedic surgeon or neurosurgeon to prepare a second opinion report resolving the disputed surgical recommendation. If no agreement is reached within 10 days, or if the employee is not represented by an attorney, an orthopedic surgeon or neurosurgeon shall be randomly selected by the administrative director to prepare a second opinion report resolving the disputed surgical recommendation. Examinations shall be scheduled on an expedited basis. The second opinion report shall be served on the parties within 45 days of receipt of the treating physician's report. If the second opinion report recommends surgery, the employer shall authorize the surgery. If the second opinion report does not recommend surgery, the employer shall file a declaration of readiness to proceed. The employer shall not be liable for medical treatment costs for the disputed surgical procedure, whether through a lien filed with the appeals board or as a self-procured medical expense, or for periods of temporary disability resulting from the surgery, if the disputed surgical procedure is performed prior to the completion of the second opinion process required by this subdivision.

DECISION

The WCAB in an *en banc* decision indicated that a request for lumbar spinal fusion surgery requires utilization of Labor Code §4062(b). However, they also felt that the Defendant was still required to provide utilization review of the request for spinal surgery under Labor Code §4610 and that that procedure was still required. Specifically, any request for medical treatment that is not being provided and is being delayed for review, must undergo Utilization Review. This step is still required under Labor Code §4062(b), and that if upon review Utilization Review approves the surgery, then Defendant is required to provide the surgery. But if Defendant fails to timely complete the Utilization Review, Defendant is also required to provide the surgery.

Only if Utilization Review denies spinal surgery, and that the denial was timely, then a Labor Code §4062(b) objection must be made within the same 10-day time period, which is from receipt of the report, and then you are allowed to then go forward with the second opinion process.

PRACTICE POINTERS

This case essentially points out that you cannot bypass the UR process. Although Labor Code §4062(b) does not specifically suggest that UR is required, this case now finds that a spinal surgery request must not only be earmarked from the date of receipt, but must undergo the UR process within the necessary timeframe in order for Defendant to not only get the UR process started, but also completed within 10 days, so that if surgery is not recommended, Defendant can then file a timely objection under Labor Code §4062(b) and start the second opinion process. Under those arduous circumstances, a second opinion can be obtained by Defendant. Otherwise, anything short of that will require Defendant to provide the surgery. Thus, any spinal surgery request, if clearly marked, must be earmarked by Defendant immediately to UR process and review. Of course any spinal surgery request should be subject to a second opinion, and as a

practice pointer, any surgery request should be immediately reviewed within the 5-day timeframe from the date of receipt for process and submission and a decision finding that the surgery was not necessary. Of course if the UR review finds the surgery recommended, then you are to authorize the surgery immediately. If the UR process was untimely, you must also provide the surgery under those circumstances.

Again only if you have a request for spinal surgery that is timely reviewed and timely denied by UR, and the <u>Defendant</u> issued a timely objection under Labor Code §4062(b) within <u>10</u> days from the date of receipt of the report, can you then prompt the second opinion spinal surgery process.

Again, in practice, this is a very difficult task to complete within the timeframes required in order to get a second opinion. However, with spinal surgery at issue, which is certain to be costly in order TTD, but also medical treatment and permanent disability, it is urged that any spinal surgery request be earmarked for immediate review, response and objection. Again, the Board has specifically ruled out the option of bypassing the UR process. Finally, this case also stands for the proposition that it is not the Applicant's obligation to object under Labor Code §4062(b), but rather Defendant's obligation, even though the UR denial is in support of their objection.

BRUCE KNIGHT v. United Parcel Service, (2006) 71 Cal. Comp. Cas 1423.

FACTS OF THE CASE

This case involved an MPN. The employer in this case, United Parcel Service, was insured by Liberty Mutual, and the Applicant has an injury on 2/22/2005 to his right wrist, arm and shoulder. Applicant treated at U.S. HealthWorks and later was referred to a Dr. Zoppi for consultation. Dr. Zoppi issued his initial medical report and findings and Applicant then obtained representation and attempted to change treating doctors to Dr. Robert Hunt. Defendant objected to the election indicating that Dr. Hunt was not a member of Liberty's MPN panel and therefore they would not authorize or provide or pay for any treatment provided by Dr. Hunt.

Applicant attorney took the position that the MPN was not valid given that there was no evidence of the Employee being aware of the MPN prior to the injury or subsequent to the election of Dr. Hunt as the PTP. Defendant's response indicated that they would provide a list of MPN doctors that the applicant could choose from in order to select a doctor that is within their panel. Applicant responded to that suggestion by electing another doctor [Dr. Rabinovich] to be the treating doctor outside of the MPN. Defendant then sent an objection letter to Dr. Rabinovich suggesting that he was not a member of the MPN panel and therefore no treatment would be authorized. This was the first evidence of any written notice from Defendant to the Applicant and his attorney that refers to the existence of the MPN. As a result, Applicant attorney asserted that the MPN was not properly put in place in this matter and therefore he can elect anyone he wished under Labor Code §4600.

Defendant again denied treatment and the Applicant filed a DOR. Applicant testified at the hearing that he had not received any notices of the MPN prior to the injury or after his injury until the objection letter to Dr. Rabinovich. Defendant offered no additional evidence and the judge issued a decision finding that the Defendant had waived its right to assert the MPN. A Petition for Reconsideration was filed asserting that an MPN provider must be required.

ISSUE

At issue is whether or not Defendant's MPN panel was properly placed in this matter so that the MPN can be enforced as the sole treater of this industrial injury.

LAW

Labor Code §4600 allows the employer to select their own treating physician within 30 days following an injury. Under SB 899, however, Labor Code §4600(c) was amended so that if the employer had established an MPN, the election of a doctor within 30 days from the date of injury was no longer allowed. Under those circumstances, the MPN provides, however an Applicant can select a different doctor within the MPN. Finally, Labor Code §4616 and California Code of Regulations Section 9767.3 provide the requirements for an MPN to be properly put in place in order for it to be enforced. Specifically, §4616.3 states as follows:

(a) "When the injured employee notifies the employer of the injury or files a claim for workers' compensation with the employer, the employer shall arrange an initial medical evaluation and begin treatment as required by Section 4600."

(b) "The employer shall notify the employee of his or her right to be treated by a physician of his or her choice after the first visit from the medical provider network established pursuant to this article, and the method by which the list of participating providers may be accessed by the employee."

(c) "If an injured employee disputes either the diagnosis or the treatment prescribed by the treating physician, the employee may seek the opinion of another physician in the medical provider network. If the injured employee disputes the diagnosis or treatment prescribed by the second physician, the employee may seek the opinion of a third physician in the medical provider network."

California Code of Regulations §9767.12(a) provides additional requirements to include providing the injured worker notice of how to implement the MPN. This notice must be provided at the time of hire or when an existing employee transfers into the MPN. The notice should also be in English and Spanish if appropriate.

DECISION

Essentially the WCAB, in an *en banc* decision, held that Defendant failed to provide the proper notices to enforce the MPN on this case. Without notice, the Applicant was not provided rights, and without a provision of rights, the enforcement of a limitation of treatment cannot be upheld. The Court noted that written notices of workers' compensation rights and treatment are provided to every employee by their employer even before MPNs are put in place. If there is not a limitation of treatment following an injury at work, that limitation must be provided to each and every worker, even prior to injuries. In this case, the Labor Code and the Regulations clearly provide employers and carriers with the instructions on how to provide those proper notices. Secondly, following an injury notices should also issue if one's benefits are being affected. In the instant case, Defendant was attempting to assert an MPN, and did not notify the Applicant of the MPN until much later and well after the injury was filed. Neglect or refusal to provide medical treatment in this situation results in the provision of that treatment even if self-procured. As a result, the decision was that the employer's or insurer's failure to provide required notices

to the employee of his rights under the MPN essentially results in a neglect or refusal to provide reasonable medical treatment and, as such, the employee is entitled to reasonable medical treatment self-procured by the employee.

PRACTICE POINTERS

Essentially, those employers who wish to assert an MPN and enforce an MPN can use this case as a guide as to what must be required by a Defendant to enforce an MPN at trial.

First of all, there is a requirement prior to the implementation of an MPN that an employee be notified in writing about the use of the MPN. Secondly, there is a requirement to provide the MPN rules and regulations at the time of injury. Applicants should be made aware of their right to select an MPN doctor who will treat them, and what they need to do to change treating doctors within the MPN. In the instant case, the Applicant was never apprised of his or her rights to a second or third opinion on treatment diagnosis and was not provided information as to how to access MPN physicians.

In summary, unless each and every requirement under the *Knight* decision is adhered to by the employer and carrier, Applicant attorneys will assert this case as the blueprint to get their injured workers out of the MPN. In practice, an out of MPN physician is likely to include the sleep disorder, sexual dysfunction and psychiatric add-ons, as they will likely have selected a doctor outside of the MPN that is willing to recommend the referral.

JOHN C. DUNCAN v. Workers' Compensation Appeals Board, X.S.(formerly known as XYZZX SJO2), (2009) 74 Cal. Comp. Cas 1427.

FACTS OF THE CASE

This case involves a Coast of Living Adjustment (COLA) pursuant to Labor Code §4659(c) for life pension and total permanent disability indemnity. The Applicant suffered an injury on 1/20/2004, which was settled on 6/19/2007. As part of that settlement, the parties stipulated that the Applicant became Permanent & Stationary on 10/20/2006, and that the permanent disability was 69.5% for which benefits should have initiated a $200.00 per week after 10/20/2006, for a period of 437 weeks.

Because the Applicant had a prior Hepatitis B and HIV positive status, the injured worker also filed a claim with the Subsequent Injuries Fund and by 3/25/2008 the Subsequent Injuries Fund and the injured worker entered into an agreement that the Applicant was 100% disabled based on the combined disability of his non-industrial condition and industrial condition. As a result the Applicant was to receive $528.00 per week as total permanent disability as of 10/20/2006 for 422 weeks, and thereafter $728.00 weekly for life.

ISSUE

Although the $728.00 weekly rate started as of 10/20/2006, a dispute arose as to whether there was a need to increase the amount based on the COLA and when that increase should start.

The judge issued a decision that since the Subsequent Injuries Fund failed to properly apply the COLA, that benefits were to be increased as a result starting 1/1/2005 and onward.

The decision was appealed by the Subsequent Injuries Fund, and the WCAB addressed the issue. The WCAB issued a decision indicating that any payments made after 1/1/2004 following the date of injury shall be increased not matter when the first payment is received. The Court argued that this allows for severely injured workers to be protected against inflation, and in cases where there is years of litigation before there is a final determination as to life pension or total permanent disability benefits. The Subsequent Injuries Fund filed a Petition for Writ of Review, which was granted by the Court of Appeals.

At issue is when an increase in the state average weekly wage results in an increase in the cost of living adjustment, and when this would apply to payments of life pension and permanent total disability benefits.

LAW

Labor Code §4659(c) states, "For injuries occurring on or after January 1, 2003, an employee who becomes entitled to receive a life pension or total permanent disability indemnity as set forth in subdivisions (a) and (b) shall have that payment increased annually commencing on January 1, 2004, and each January 1 thereafter, by an amount equal to the percentage increase in the "state average weekly wage" as compared to the prior year."

DECISION

The issue raised in this case is essentially when does the adjustment take place? The Court of Appeal issued decisions that an injured worker's total permanent disability payment or life pension payment, when calculated, would be subject to a COLA starting from 1/1/2004 and every January 1 thereafter. The Court of Appeal essentially indicated that this was the clear language of the statute and, as such, this decision has had an impact on many types of benefits.

PRACTICE POINTERS

COLA affects, at this point in time, temporary total disability benefits each year when maximums and minimums are adjusted. Similarly, death benefits are also adjusted, as well as life pension and permanent total disability.

In this case, only the total permanent disability issue was in question, and even though benefits do not initiate until 2006, the PD rate was adjusted beginning 1/1/2004. Even though those benefits did not commence until well after, those incremental increases still apply. As an example, if an injury occurred in 2009 and life pension started in 2015, adjustments for that life pension would start in 2004. Over the past five years, increased have been noted in the state average weekly wage, resulting in cost of living increases from anywhere from 1.97% to 4.9%. As such, permanent disability benefits are now adjusted under permanent total disability claims for both maximum and minimal limits, and then the adjustments for each and every year become more and more difficult to ascertain and calculate.

Although the SAWW increases are available under the Department of Labor websites, again it is a very complicated mathematical procedure that must be used in determining when a total permanent disability award is addressed and calculated for the many years thereafter. In efforts to try to resolve a total permanent disability claim, cost of living adjustments of further years in the future cannot be properly predicted as the cost of living increase cannot be predicted with any certainty over the next few years.

As such, this case makes it much more difficult to provide anyone with a clear understanding of what a total permanent disability award will be in the past and future. Similarly, life pension awards will also be difficult to ascertain its value over the life of a decision.

BRICE SANDHAGEN v. Workers' Compensation Appeals Board, State Compensation Insurance Fund, (2009) 74 Cal. Comp. Cas 835.

FACTS OF THE CASE

Applicant was involved in a car accident in 10/2003 that resulted in medical treatment. During the period of treatment, the treating doctor recommended an MRI of the neck and upper back in a report dated 5/14/2004. This report was faxed to Defendant State Compensation Insurance Fund on 5/24/2004 with a request to authorize the recommended MRI. State Compensation Insurance Fund referred the request to their UR Department and 20 days later issued a denial citing new medical treatment guidelines. Prior to the denial, Applicant filed a Request for an Expedited Hearing on the grounds that Defendant failed to issue a timely UR denial under Labor Code §4610(g)(1) and that the treatment should be authorized as a result. The WCJ found that failure to comply with UR deadlines barred the UR report, and therefore the only admissible report was the treating doctor's report finding the need for the MRI. The Defendant sought reconsideration, asserting that even if untimely, the report should be inadmissible. A delay should be dealt with the administrative penalty instead. Applicant answered indicating that the Labor Code requires that an employer meet the specific time deadlines and, if not, should not be able to use the report to justify denial of treatment.

The WCAB granted reconsideration and issued an *en banc* decision.

The WCAB issued a decision as of 11/16/2004 indicating that UR deadlines are mandatory, and if not met the UR process is precluded from being used as evidence to dispute medical treatment in question.

This decision also suggests that that report also be precluded from being reviewed by an AME or a QME later on. Finally, the decision also asserted that the deadlines under Labor Code §4610(g)(1) can be extended by agreement by the parties, but even if the deadlines are not reached, the Defendant can utilize Labor Code 4662(a) and object to the treating physician's treatment recommendations and proceed with the AME/QME process. State Fund issued a Petition for Writ of Review, as did the Applicant, and the Court of Appeal reviewed the decision.

ISSUE

At issue is how to interpret Labor Code §4610 in determining whether or not medical treatment can be provided, and how to dispute medical treatment issues.

LAW

Labor Code §4610(g)(1) states in part, "In determining whether to approve, modify, delay, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees all of the following requirements must be met:
(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination."

DECISION

The Court of Appeal indicated that, first of all, employers are not required to apply UR to each and every request for treatment. Labor Code §4610 is to be used when there is a medical treatment request that is subject to question and, as a result, may be delayed, modified, approved or denied. Under these circumstances, the Court of Appeal indicated that in order to question a medical treatment request, UR must be utilized.

As to Defendant's argument that they could opt out of the UR process by proceeding with a Labor Code §4062 objection, the Court of Appeal further indicated that Labor Code §4062 precludes an employer from using its provisions to object to Applicant's treatment request, but it permits Applicants to use its provisions to object to Defendant's decisions regarding treatment requests. Essentially, Labor Code §4062 can be utilized to object to a treatment decision by Applicant only. If a Defendant properly utilizes UR timely, and the decision is to provide the treatment in question, there is no issue. Only if the decision is to modify or deny the treatment, whether it be in dispute and that dispute will be raised by applicant. Under those circumstances, Labor Code §4062 allows Applicant to proceed with a second opinion by way of a QME or QME if represented. As a result, UR process is required for every disputed medical treatment request, and that only an Applicant may invoke §4062 to dispute a medical treatment request.

PRACTICE POINTERS

This decision, issued on 7/16/2009, was met with much approval by the medical provider community. Medical treatment that was being denied, delayed or modified must be met with a timely and proper UR denial in order for that decision to be upheld and disputed. Failing that, treatment must be authorized. Thus, at every hearing where a medical provider's treatment is being disputed, is being denied or rejected, the first question asked on admitted injuries is where your UR denial? That UR denial is then subject to scrutiny as to whether it is timely and appropriate in its content.

This decision also suggests that if a timely UR denial is issued, then only Applicant can invoke the §4062 process.

If the UR recommendation was to certify the request for treatment, Defendant is left with only the option of providing the treatment in question as opposed to objecting under §4062 themselves.

As a practice pointer, UR is to be used not in every circumstance, but in appropriate circumstances. Treatment that is questionable should be addressed through the UR process, with the proper timeframes being enforced. Efforts to not over utilize UR and over apply simple therapy requests or over examine treatment requests that are well within reason should not have to go through the UR process to be approved by Defendant.

LAWRENCE WEINER v. Ralphs Company, (2009) 74 Cal. Comp. Cas 736.

FACTS OF THE CASE

This case presents an Applicant who had a valid claim for retroactive VR benefits. The Applicant in this case suffered an injury by way of continuous trauma through 2002, although the Applicant voluntarily retired following the injury and was offered a pension. However, from that point on the Applicant claimed that he was ready, willing and able to participate in voc rehab through 3/7/2005. Applicant filed a Request for Rehab Services as of 6/7/2003, and the Applicant was found to be QIW by the treating doctor as well, as of 6/15/2004. At that point in time a second demand for rehab was issued. On 3/8/2005 the Defendant accepted the injury and provided rehab services. Later, the applicant was evaluated by an AME [Dr. Angerman] on 3/31/2005 and Applicant was again found to be QIW. Applicant then participated in rehab through 3/26/2008, when Defendant requested a closure of rehabilitation. At that point in time the Applicant's case-in-chief also went to trial and an F & A was issued on 4/8/2008 finding the applicant 60% disabled.

On 7/7/2008, a Rehab Unit hearing was held and at that point retroactive VR benefits were argued at the TTD rate for the point in time of 6/13/2003, the day of the initial request for voc rehab, through 3/7/2005, when rehab services were later commenced. The Rehab Unit issued a decision indicating that the applicant was indeed entitled to VR at the TTD rate for that period in question. A timely appeal was filed by Defendant and the matter was set for a hearing before a WCJ on 11/24/2008. The matter was submitted at that point.

A decision was later issued on 1/13/2009 by that same WCJ, finding that the Applicant was indeed entitled to that retro VRMA at the TTD rate for the period in question, 6/13/2003 through 3/7/2005. Defendant filed a Petition for Reconsideration arguing that the WCJ had no right to issue a decision awarding retro VRMA because the legislature had repealed the voc rehab statute [§139.5] effective 1/1/2009 and therefore had no ability to issue an award or any retro VRMA. Defendant further argued that the right to voc rehab benefits is only statutory and that statute was repealed. The repealed statute stops all pending actions, and therefore any and all rights to voc rehab benefits were abolished when the statute was repealed as of 1/1/2009.

Applicant filed an Answer contending that the retro VRMA at the TTD rate is based on the statutory law in effect at the time these benefits should have been provided, and therefore can be still awarded.

ISSUE

At issue is whether or not the repeal of Labor Code §139.5 effectively rules out the ability for the Appeals Board to Award any services under vocational rehabilitation.

DECISION

As part of the SB 899 legislation vocational rehabilitation was drastically reduced in its scope. Specifically, services were no longer being provided, and that the most the Applicant could obtain would be a voucher. However, for injuries before SB 899 came into effect, Labor Code §139.5 was statutorily repealed as of 1/1/2009. Labor Code §139.5 was a statute that provided the provision for any and all rehabilitation services.

At the time of the SB 899 legislation, it was believed that by 1/1/2009 another provision under the Labor Code would be enacted that would allow for some type of vocational services. However, that never took place.

As a result, the WCAB, in its decision *en banc,* looked at the history of vocational rehabilitation services in California and believed that the repeal of §139.5 essentially terminated any rights to vocational rehabilitation benefits or services unless an order or award that was filed issued before 1/1/2009. Looking at the intent of the law and the clear repeal of the law, the WCAB believed that the intent of the legislation was to eliminate vocational rehabilitation services, as the intent of the entire legislation was to reduce benefits and costs.

Furthermore, they found no statutory right to allow the award of benefits post 1/1/2009, unless there was a final order or award. Since there was no later adoption of legislation to protect vocational rehabilitation services after 1/1/2009, essentially the Court had no choice but to rule that the decision issued after 1/1/2009 could not be enforced. After the repeal of §139.5, the WCAB only has jurisdiction over voc rehab issues, whether there is an enforcement of a combination of vested rights.

PRACTICE POINTERS

This case essentially provided Defendant with the ability to argue that any and all claims for vocational rehabilitation services after 1/1/2009 are no longer enforceable. Prior to 1/1/2009, Defendant received a ration of requests for rehab services by Applicant attorneys in efforts to try to preserve any and all possible right to services, but unless there was a final order or award prior to 1/1/2009, those services are no longer available under any circumstance.

ALMARAZ v. Environmental Recovery Services/GUZMAN v. Milpitas Unified School District (2009) 74 CCC 474, 74 CCC 1080.

FACTS OF THE CASE

These cases were so similar in factual pattern and issue that they were consolidated and decided together by the Workers' Compensation Appeals Board *en banc*. In the *Almaraz* case, Applicant sustained a back injury on 11/5/2004, had back surgery and never returned to work. The parties went to an AME [Dr. Fishman], who issued a report, finding under AMA Guides a 12% Whole Person Impairment. Applicant was given a light duty work restriction and precluded from prolonged sitting.

It was determined that under the new guidelines, the Applicant would be entitled to 14% permanent disability, but under the old guidelines, the Applicant would have received 58% permanent disability. Based on this disparity of disability findings, Applicant filed a Petition for Reconsideration contending that the AMA Guides and the new Rating Manual is rebuttable and that the AMA Guides should not be blindly followed.

In the *Guzman* case, Applicant sustained a continuous trauma injury to both upper extremities, through 4/11/2005, while employed as a secretary. The AME in that matter found 3% Whole Person Impairment for each extremity based on the AMA Guides, but also noted that based on her activities of daily living, the upper extremities should have been a 15% Whole Person Impairment, which is a method not sanctioned by the AMA Guides. Thus, the combined disability would have been 39%, under the activities of daily living.

A 12% award was issued and Applicant filed for reconsideration, arguing that the AMA Guides should defer to the evaluator’s clinical judgment.

ISSUES

In both these cases, there was a great disparity in opinion by the AME doctors as to what the AMA Guides would provide and what both doctors felt would be a more appropriate method of determining the disability value of the claim. On both cases, the Applicant attorneys argued that the AMA guides were simply guides that do not always have to be followed. Essentially they were arguing that the PDRS adopted post SB 899 has created a substantial savings in permanent disability, which was the purpose of the new guidelines, were rebuttable. Specifically, they were rebuttable as to the methods of determining the Whole Person Impairment factor.

Both cases were granted reconsideration and consolidated together and decided on 2/3/2009.

DECISION

On 2/3/2009 the initial decision on this case was that both cases made compelling arguments as to why the AMA Guides were guides only that can be rebutted. Ultimately the Court decided that the PDRS was indeed rebuttable if it could be shown that the impairment rating based on the AMA Guides would result in a permanent disability award that would be inequitable, disproportionate and not a fair and accurate measure on the applicant's permanent disability. Once you are able to show this disproportionate factor, then a new impairment rating can be issued by an evaluating doctor based on that doctor's medical opinions that are not based, or are only partially based on the AMA Guides.

That doctor essentially was to use any other method that he chooses to determine what would be a fair and accurate measure of the employee's permanent disability, using whatever evidence or medical literature that he could find to support the position, other than the old Rating Manual.

The case was remanded back to the WCJ for further proceedings.

Shortly thereafter Defendants filed another Petition for Reconsideration contending that if there was a finding that the AMA Guides were rebuttable, then it would be inconsistent with the legislative intent that the Schedule "promote consistency, uniformity and objectivity." It also is contrary to the legislature's intent to reduce costs and provide a reliable determination of one's disability.

That Petition for Reconsideration in *Almaraz* was granted and the matters were consolidated.

A second decision was issued on 9/3/2009, *Almaraz/Guzman II*, in which the Court, after reviewing a substantial amount of *amicus* briefs, finally concluded that the PD rating portion of the Schedule is rebuttable and that the party disputing a scheduled permanent disability rating has the burden of rebutting it.

In order to do so, one must show that the ratings under the new schedule would not be the most accurate way of determining an injured worker's impairment. Instead, using the four corners of the AMA guides, when determining an injured employee's Whole Person Impairment, it is not permissible to go outside of the four corners of the AMA, but within the four corners, a physician may utilize any chapter, table or method in the AMA Guides that would more accurately reflect the applicant's impairment.

This second decision specifically rejects the inequitable, disproportionate, and not a fair and accurate measure of the employee's permanent disability standard, and now simply puts in the standard that a more accurate reflection of an injured worker's impairment can be obtained by using an alternate method of the AMA Guides.
Essentially, the decision allows an injured worker to argue that the AMA Guides, under the new Rating Schedule, as applied to that injured worker, would not be the most accurate reflection of that person's disability. Instead, something else within the AMA Guides would be more

accurate, and can be used if an argument can be made, and that argument is deemed substantial evidence.

PRACTICE POINTERS

This case is currently on appeal, but while on appeal, it is good law. Therefore, most every Applicant attorney is asking every doctor evaluating injured workers to address the *Almaraz/Guzman II* decision. Essentially, if the evaluating physician feels that the AMA Guides' rating of an injured worker would not be an accurate reflection of that person's disability, then creative arguments can be made within the AMA Guides to increase the value of a claim. Again, every doctor is being asked to address this case, and some are coming in with additional or higher findings using alternate methods of the AMA Guides. Creative analogies are being made, and essentially the argument can be made in every case, but not successfully. The best case scenario would be an injured worker whose injury was rather severe, but whose disability under the AMA Guides was rather low. Again, in these cases, the disability findings under the AMA Guides were low in comparison to other methods of determining disability. It is that type of situation or case that would be best suited for this type of litigation, and in order to prove up your case you must have substantial evidence by your evaluating physician.

That evaluating physician must make the argument not only that the AMA Guides' rating would be an inaccurate measure, but that there is a more accurate measure within the AMA Guides that can be used.

This is a high standard to reach, and there is minimal or no guideline as to what is considered accurate. Is the AMA Guide as drafted accurate? Is the old schedule more accurate? How does one determine what is accurate and then invoke this case to give a higher rating as a result? All these questions are still unanswered, and during the early infancy of litigation over these issues, Applicant attorneys are arguing primarily that any low impairment finding on a rather serious injury will be subject to attack. Again, in this case the AMA Guides gave very low levels of disability in light of the other factors of determining what ratable permanent disability is.

A judge is allowed to make a decision using the range of evidence, and therefore even if a doctor suggests under *Almaraz/Guzman II* that a higher rating would be appropriate, again a judge is given the discretion of using a range of evidence.

Judges will look more closely at the objective factors of disability that seem to correlate with the subjective factors, and the use of other areas of the AMA Guides to determine disability value.

Whatever findings the doctor issues, unless the report is deemed substantial evidence, the report is worthless.

Applicant attorneys in efforts to get the *Almaraz/Guzman II* decision on their matter will likely argue that their injury is not the same as other injured workers suffering the same injury due to some disparity in that person's condition rendering the idea that a higher level disability would be not only fair but appropriate.

The AMA Guides, as written, were designed to provide disability findings for the reasonable and average man, but if the applicant is somewhat different in shape, size and education, then a different standard might be made available, however, only within the four corners of the AMA Guides.

Based on this decision, we anticipate a substantial amount of litigation over this issue, but so far the litigation has been slow to come, and hard to argue. There are no real guidelines as to how far an injured worker can go in referencing this decision and a higher level of disability.

Therefore we shall see how it is litigated and how it is adjudicated, and we will see if the law is upheld as well.

In the meantime, until then, Applicant attorneys can rebut the Rating Manual under the appropriate circumstances.

***WANDA OGILVIE v. City and County of San Francisco* (2009) 74 CCC 478, 74 CCC 1127.**

FACTS OF THE CASE

This case presents an attack on the new PD Rating Schedule (PDRS) attempting to argue that the DFEC variant can be rebutted. Specifically, under the new Rating Manual, not only is the age and occupation variant still present, but they added a third variant, the Diminished Future Earning Capacity Variant. This variant increases the disability values of a claim, depending on the body part injured, using empirical data gathered. However, the fallacy in the argument is that every injured worker who has an injury involving the same body part would have essentially the same diminished future earning capacity. Applicant attorney in this particular case argued that the diminished future earning capacity was higher, and that he should be able to rebut the variant as given by the PDRS.

As a result, the Applicant attorney filed a Petition for Reconsideration asking that the Appeals Board allow evidence to rebut the DFEC, so that a higher disability value rating can be obtained.

ISSUE

At issue is whether or not the DFEC portion of the 2005 PDRS is rebuttable and, if so, to what extent?

DECISION

In the case-in-chief, the Applicant and Defendant both produced witnesses [vocational rehabilitation experts] who testified that after reviewing the injured worker's economic status, background and work history that the diminished future earning capacity was more in the 51% to 53% range. 20% PD was found under normal circumstances, but the judge issued an award of 40% after reviewing the vocational rehabilitation experts' opinions. Believing that that would be the more accurate and fair reflection of the disability, he found the higher amount. Essentially, the WCJ found that the 2009 Schedule was rebuttable as to the DFEC.

That issue was brought to the Appeals Board, and in an *en banc* decision, the WCJ decided the following:

(1) The DFEC portion of the rating schedule is rebuttable;
(2) The scheduled is *not* rebutted by the percentage to which an injured employee's future earning capacity has been diminished;
(3) The schedule is *not* rebutted by taking two-thirds of the injured employee's estimated diminished future earnings, and then comparing the resulting sum to the permanent disability money chart to approximate a corresponding permanent disability rating; and
(4) The DFEC portion of the 2005 Schedule may be rebutted in a manner consistent with Labor Code §4660.

Using Labor Code §4660 as a guide, the Board has set out a method for one to make a DFEC adjustment factor argument to rebut the DFEC given by the Rating Manual. Two sets of wage

date must be obtained, one for the injured employee and one from a similarly situated employee, and using comparisons and a complicated mathematical formula, a DFEC adjustment factor is produced. That adjustment factor is then weighed against what the adjustment factor would be under the Rating Manual, and if difference, the other adjustment factor can be used by either party, whether it goes up or down.

As a result, Applicants can argue that the DFEC in their particular injured worker's case is higher than what would be given by the Rating Manual, and can prove it by using the data in their particular case.

PRACTICE POINTERS

Based on this decision, the Trier of fact must now receive information available from both parties on the issue of diminished future earning capacity to either approve or disprove a higher level of disability. Information needed includes projections regarding future employment earnings, usual and customary job title and wages, the nature and extent of the disability of the injured worker, the amount of job interviews, Applications, an effort the applicant has made in attempting to find work, and the injured worker's background. All these are factors that will go into account as to whether or not an applicant who, post-injury, has difficulty finding work, whether the diminished future earning capacity variant should be adjusted, and is such additional evidence may be required by both parties if an *Ogilvie* argument is raised. More than likely both parties will need expert testimony, although the *Ogilvie II* decision suggests that expert testimony will not be necessary. From the Defense side, however, the pure calculations under the *Ogilvie II* decision may result in a higher DFEC value, but testimony must be obtained by Defendant to argue to the contrary that Applicant's perceived loss of earnings was not in fact real, but rather manufactured by the Applicant either by failure to attempt to find work, malingering or a simple unwillingness to work.

As a result of this case, it is anticipated that additional litigation under the right circumstances can be raised by Applicant attorneys, which will require additional expenses and litigation on the Defense side as well.

DIANNE BENSON v. Workers' Compensation Appeals Board, The Permanente Medical Group, (2009) 72 Cal. Comp. Cas 1620

FACTS OF THE CASE

This case addresses the issue of apportionment. In the instant case the applicant had two injuries (a specific and a CT). The case went to trial, and the judge felt that both injuries found had 31% disability and combined the disability to an award of 62%. 62% equated to approximately $67,000.00. Separate awards of 31% would have been $24,000.00. However, given that the disabilities were found to be Permanent & Stationary on the same date, the trial judge, using the *Wilkinson* doctrine, which has been in placed in 1977, combined the disability.

Under the *Wilkinson* decision, an injured worker, who while employed by the same employer, suffered two separate injuries to the same part of the body, which became Permanent & Stationary at the same time. The injured worker received a combined PD award. This decision is based on Labor Code §4750, which was in existence at that time.

Under Labor Code §4750 there is no provision for disabilities that became Permanent & Stationary at the same time, and therefore the decision in that case were to simply combine the disability.

In the instant case, the judge did exactly what *Wilkinson* would have provided.

The Defendant, however, appealed, indicating that under SB 899, and under the new apportionment laws, under the Labor Code §§4663 and 4664, which now allowed apportionment to causation, that apportionment between two injuries is much easier and there is no reason not to separate the disability, regardless of when the applicant became Permanent & Stationary.

The WCAB agreed with Defendant, and the matter was appealed once again. Finally, the Court of Appeal issued a decision in 2009.

ISSUE

At issue is whether or not the *Wilkinson* doctrine should exist after SB 899 in light of the ability to apportion to causation.

DECISION

The decision reached by the Court of Appeal was to affirm the Appeals Board’s decision that an injured worked, while employed by the same employer, who sustained two separated injuries to the same part of the body, which become Permanent & Stationary at the same time, was entitled to receive separate awards, as opposed to a combined award. With post SB 899 requirements and apportionment being based on causation, and given the repeal of former Labor Code §4750,

the Court of Appeal affirmed the WCAB's findings that applicant's specific and cumulative injuries constituted two separate injuries that must be addressed separately, including in reference to permanent disability.

PRACTICE POINTERS

Most every case that we see nowadays includes a specific and a continuous trauma claim. Most every claim also has overlapping body parts, and as such most every litigated case should have the possibility of a *Benson* type apportionment. Again, Applicant attorneys will attempt to assert that the disability should be combined, which would be appropriate on a single injury, involving separate body parts. However, in cases where there are separate injuries, each injury must be separately rated, and the disabilities cannot be combined. This greatly reduces the amount of potential exposure to Defendant, as in this case the combined award would have been $67,000.00, and the separate awards would be less than $50,000.00.

Many of the doctors that are still treating injured workers, or evaluating injured workers as AMEs or QMEs are still attempting to combine disabilities, and one must be fully aware that if there are separate injuries, that the doctor must apportion accordingly. Failure on the doctor's part to apportion may grant his report not substantial evidence, and subject to attack. In evaluating a Permanent & Stationary report and a PD award, clearly the separation of disability must be clarified and clear. Although there was a suggestion that if the disabilities were inextricably intertwined so that one cannot divide the disability that was a very limited circumstance.

MARLENE ESCOBEDO v. MARSHALLS, (2005) 70 Cal. Comp. Cas 604

FACTS OF THE CASE

In this case the Applicant had a 2002 industrial injury to the left knee and right knee while employed as a sales associate by Marshalls. The case went to trial and the applicant was found to have 20% disability after determining that 50% of her PD was caused by a pre-existing, degenerative, arthritic condition in both knees. The WCJ applied Labor Code §4663 as enacted after SB 899 in apportioning to causation. Applicant appealed and the Appeals Board issued a decision *en banc.*

ISSUE

Did the WCJ properly apply Labor Code §4663 in finding apportionment?

DECISION

This case is a landmark case in how to write a report that will be held as substantial evidence on the issue of apportionment. First of all, the decision clearly separates the issue of causation of the injury as opposed to causation of permanent disability. That difference must be clearly factored into one's medical report, so that there is no confusion as to whether a doctor is apportioning to injury as opposed to permanent disability.

The decision also requires that a physician must make determinations of percentages of permanent disability directly caused by industrial injuries, and percentages caused by other factors. However, in making these determinations, Defendant has the burden of proof, and that proof must be substantial evidence. Although SB 899 now allows you to apportion to pathology and asymptomatic prior conditions and retroactive, prophylactic work restrictions, a medical report finding apportionment to these conditions must be substantial medical evidence in addressing the issue of substantial evidence, and a medical opinion must be framed in terms of reasonable medical probability that cannot be speculatively, but must be of some facts, history and examination. The conclusion must be supported by the facts and the reasoning, and in the instant case, those factors were put in place, and the report was held as substantial evidence upholding the apportionment finding.

PRACTICE POINTERS

Once again, in reviewing this decision, it is clear that in order for a finding of apportionment to be upheld, you must have a qualified doctor who can fully address the issues, including apportionment, review of records, factors of disability, and apportion by percentages. This is a difficult task, and therefore doctors who are able to apportion properly are few and far between, and should be used when dealing with apportionment issues.

Effective February 17, 2009, the Department of Industrial Relations implemented new Qualified Medical Evaluator Regulations. Amongst other things, the new regulations promote new standards for obtaining Panel QMEs, asking for replacement or multiple QMEs, and impose strict timeframes for scheduling QME appointments, cross-examinations and issuing QME reports.

The new regulations can be found in Title 8 California Code of Regulations Sections 1 through 159. Since the new regulations were implemented in February of this year, you will not find them in the Labor Code until 2010. However, the regulations can be viewed in their complete 97-page form at the Department of Industrial Relations website at

www.dir.ca.gov/dwc/DWCPropRegs/QME_regulations/QME_regulations.htm

QME ELIGIBILITY STANDARDS

Sections 1 – 20 pertain to new QME Eligibility standards. They cover such topics as the process for appointing QMEs, QME eligibility requirements, QME report writing courses, QME fees, etc. These sections essentially outline what physicians must do to become a QME and how to keep their QME status.

SPECIFIED FINANCIAL INTERESTS

Section 29 is a new regulation that attempts to prevent conflicts of interest between Panel QMEs.

Per Section 29, every physician is now required to disclose **SPECIFIED FINANCIAL INTERESTS.** Under Section 29(b) "Specified Financial Interests" means,

> "…being a general partner or limited partner in, or having an interest of five (5) percent or more in, or receiving or being legally entitled to receive a share of five (5) percent or more of the profits from, any medical practice, group practice, medical group, professional corporation, limited liability corporation, clinic or other entity that provides treatment or medical evaluation, goods or services for use in the California workers' compensation system.

This section goes on to state that each QME must file a SFI Form 124 with the Medical Director and disclose the ***specified financial interests*** when applying for appointment as a QME, when paying the annual QME fee or when applying for QME reappointment.

The Administrative Director is to use this information to avoid assigning QMEs who share specified financial interests to the same QME panel. If it is determined that two or more QMEs assigned to the same panel share specified financial interests, **any party may request a replacement QME.** If three QMEs share specified financial interests, than two of the QMEs will be replaced. If two QMEs share specified financial interests, than one of the QMEs will be replaced.

Unfortunately, the new regulations fail to indicate exactly how parties can get access to the Specified Financial Interests information. As such, it is uncertain how the parties are to determine if any of the physicians on the Panel QME list have Specified Financial Interests and request a QME replacement. Although in later sections, it is suggested that once a Panel QME List is issued, any doctor that is aware of the overlapping Specified Financial Interests with other doctors on the Panel, must advise the Medical Director of the conflict.

QME PANEL REQUESTS

Beginning with Section 30, the new regulations implement a new process for requesting a Panel QME List and create new forms to be utilized when requesting a Panel QME. Although the new regulations were effective as of February 17, 2009, the DWC - Medical Unit Manager has advised that the old forms can still be used until May 19, 2009.

Under Section 30(a), in unrepresented cases, the parties are to now use revised QME Form 105 (rev. February 2009) entitled **REQUEST FOR QME PANEL UNDER LABOR CODE SECTION 4062.1 UNREPRESENTED.**

§ 30. QME Panel Requests

(a) Unrepresented cases. Whenever an injured worker is not represented by an attorney and either the employee or the claims administrator requests a QME panel pursuant to Labor Code section 4062.1, the request shall be submitted on the form in section 105 (Request for QME Panel under Labor Code Section 4062.1)(See, 8 Cal. Code Regs. § 105). The claims administrator (or if none the employer) shall provide Form 105 along with the Attachment to Form 105 (How to Request a Qualified Medical Evaluator if you do not have an Attorney) to the unrepresented employee by means of personal delivery or by first class or certified mailing.

Under Section 30(b), in represented cases, the parties are to now use revised QME Form 106 (rev. February 2009) entitled **REQUEST FOR QME PANEL UNDER LABOR CODE SECTION 4062.2 REPRESENTED.**

(b) Represented cases. Requests for a QME panel in a represented case, for all cases with a date of injury on or after January 1, 2005, and for all other cases where represented parties agree to obtain a panel of Qualified Medical Evaluators pursuant to the process in Labor Code section 4062.2, shall be submitted on the form in section 106 (Request for a QME Panel under Labor Code Section 4062.2)(See, 8 Cal. Code Regs. § 106). The party requesting a QME panel shall: 1) identify the disputed issue that requires a comprehensive medical/legal report to be resolved; 2) attach a copy of the written proposal, naming one or more physicians to be an Agreed Medical Evaluator, that was sent to the opposing party once the dispute arose; 3) designate a specialty for the QME panel requested; 4) state the specialty preferred by the opposing party, if known; and 5) state the specialty of the treating physician. In represented cases with dates of injury prior to January 1, 2005, and only upon the parties' agreement to obtain a QME panel pursuant to Labor Code section 4062.2, the party requesting a QME panel shall submit QME Form 106 in compliance with this section and provide written evidence of the parties' agreement. Once such a panel in a represented case with a date of injury prior to January 1, 2005, is issued, the parties shall be bound by the timelines and process as described in Labor Code section 4062.2.

Under Section 30(c), if the new Panel QME forms are not used, are incomplete or improperly completed, the request form shall be returned to the requesting party with an explanation as to why the Panel QME list cannot be issued.

Also, the Medical Director can ask for additional information from one or both parties needed to resolve the panel request before issuing the Panel. Reasonable information includes but is not limited to whether a QME panel previously issued to the injured worker was used.

DENIED CASES

The new regulations significantly impact how we, as defendants, will now handle denied claims. Previously, during the first 90-days of a claim, defendants may not have enough time to obtain a Panel QME to address the issue of AOE/COE, i.e. compensability. As such, if a Panel QME could not be obtained within the first 90 days, and if during the AOE/COE investigation a legal or factual basis arose to deny the claim, defendants would typically issue a denial letter. Subsequent thereto, the defendant would then later obtain a Panel QME to cover AOE/COE from a medical standpoint. The new regulations now preclude a defendant from taking this approach to denied claims.

First, let's deal with the situation when a Panel QME can obtained within the first 90 days after a claim form is filed.

Section 30(d)(1) states,

> After a claim form has been filed, the claims administrator, or if none the employer**,** may request a panel of Qualified Medical Evaluators only as provided in Labor Code section 4060, to determine whether to accept or reject a claim within the ninety (90) day period for rejecting liability in Labor Code section 5402(b), and only after providing evidence of compliance with Labor Code Section 4062.1 or 4062.2.

So, per Section 30(d)(1), after the applicant has filed a claim form, either party can request a Panel QME List to determine AOE/COE. To do so a party must first comply with Labor Code Sections 4062.1 (in unrepresented cases) or Labor Code Section 4062.2 (in represented cases).

In an unrepresented case, Labor Code Section 4062.1 requires that

(1) the employer/claims administrator furnish the applicant the QME Form 105 REQUEST FOR PANEL QME UNDER LABOR CODE SECTION 4062.1, and

(2) the employer not submit the form unless the applicant has not submitted the form within 10 days after the employer/claims administrator has furnished the form to the applicant and requested the applicant to submit the form.

The party submitting the request form shall designate the specialty of the physicians that will be assigned to the panel.

In a represented case, Labor Code Section 4062.2 requires that a party,

(1) make a written request naming at least one proposed physician to be the agreed medical evaluator,

(2) if no agreement is reached within 10 days after the AME proposal, or any additional time not to exceed 20 days agreed to by the parties, either party may request the assignment of a three member panel of qualified medical evaluators.

When making a Labor Code Section 4062.2 request, it is important to note that after a Labor Code Section 4062.2 objection is made and a written proposal naming one potential AME is issued, the first day that either party can request a Panel QME is the 11th day. Any requests made on the 10th day will be kicked back.

Also, Labor Code Section 4062.2 states that ***either party*** making the request can submit the Panel QME Request Form. So if the defendant issues the objection that means that applicant's attorney can request the Panel QME form and vice versa. Therefore, since either party can submit the request form, I would diary your file for the 11th day and submit the request form on the 11th day to maintain some control over the specialty of the Panel QME. By timely filing the request form, this improves our chances of preventing applicant's attorney from filing a request for a Panel QME in chiropractic or pain management. That being said, the new regulations do provide additional limitations on the party's ability to control the specialty of the Panel QME. This will be discussed later.

So even under the new regulations, if a defendant obtains a Panel QME report within the first 90 days, and denies the claim based upon the Panel QME within the 90-day period, there are really no limitations. The problems arise when a Panel QME cannot be obtained in time to deny the claim and defendant issues a denial based upon some other reason other than the findings of the Panel QME. Section 30(d)(3), discusses this limitation as follows:

> Whenever an injury or illness claim of an employee has been denied entirely by the claims administrator, or if none by the employer, ***only the employee may request a panel of Qualified Medical Evaluators***, as provided in Labor Code sections 4060(d) and 4062.1 if unrepresented, or as provided in Labor Code sections 4060(c) and 4062.2 if represented.

Thus, in a situation where defendants deny a claim without first requesting a panel of Qualified Medical Evaluators, the defendant cannot later request a Panel QME on AOE/COE, but for one exception found under Section 30(d)(4),

> After the ninety (90) day period specified in Labor Code section 5402(b) for denying liability has expired, a request from the claims administrator, or if none from the employer, for a QME panel to determine compensability shall only be issued upon presentation of a finding and decision issued by a Workers' Compensation Administrative Law Judge that the presumption in section 5402(b) has been rebutted and an order that a QME panel should be issued to determine compensability. The order shall also specify the residential or, if applicable, the employment-based zip code from which to select evaluators and either the medical specialty of the panel or which party may select the medical specialty.

Under this section, if defendants deny a claim without first requesting a Panel QME, then the only way they can request a Panel QME on AOE/COE thereafter is if they are (1) able to rebut the presumption of correctness of Labor Code Section 5402(b) with evidence that was not reasonably discoverable within the first 90 days after the claim form is filed, and (2) they obtain a Findings and Award from the WCALJ finding that the presumption has been rebutted and that a Panel QME list should be issued to determine compensability. As you can see this is an extremely limited exception, and will only apply in the rare cases.

So given the problems with obtaining Panel QMEs within the first 90-days of a claim, it would appear that the new regulations will make it more difficult to deny an applicant's case based upon a medical basis. In most cases, it will take immediate action from the employer to advise the insurance carrier or a claims administrator that a claim has been filed. Upon notification of a claims filing, a quick determination must be made as to whether there is a legal or factual basis to deny the claim. If there is none, then within the first few weeks the process for requesting a Panel QME must be initiated under Labor Sections 4062.1 or 4062.2, so that defendants have some medical basis to possibly deny a claim. Otherwise, a defendant may be precluded from ever obtaining a Panel QME on the issue of AOE/COE.

The question then arises, if a defendant denies a case without requesting a Panel QME, loses at AOE/COE Trial so that the claim becomes admitted, can this defendant then obtain a Panel QME on any other issues, such as temporary disability, permanent disability, medical treatment, etc? This question seems to be answered by Section 30(d)(2),

> Once the claims administrator, or if none, the employer, has accepted as compensable- injury to any body part in the claim, a request for a panel QME may only be filed based on a dispute arising under Labor Code section 4061 or 4062.

This portion of the new regulations seems to suggest that if the defendant loses at an AOE/COE Trial without the benefit of requesting a Panel QME before the denial, then once the case becomes admitted they can later Request a Panel QME to address any other issue, aside from AOE/COE. Labor Code Section 4061 deals with issues of permanent impairment or disability dispute. Labor Code Section 4062 deals with any other issue outside of AOE/COE and permanent impairment, aside from medical treatment recommendations that are subject to Utilization Review. It appears that any request for a Panel QME to address an objection to medical treatment recommendations will be denied. Instead, this issue is to be determined by the Utilization Review process.

Some miscellaneous issues address by section 30 are: when an applicant no longer resides in California, Section 30(e), states that the applicant and defendant are to agree upon the geographic area within California from which QMEs will be selected. If no agreement can be reached between the parties, then the geographic area of the QME panel selection shall be determined by where the applicant last resided in California (in unrepresented cases) or where the applicant's attorney's office is located (in represented cases).

Section 30(g) requires in represented case, the Panel QME Request Form be sent to the Medical Unit address on the QME Form 106 by means of first class mail delivered by the United States postal service. The Medical Unit will not accept panel requests in represented cases that are delivered in person by a party, the party's attorney, any other person or by other commercial courier or delivery services.

Section 30(h) states that the time periods to strike QME names specified in Labor Code sections 4062.1(c) and 4062.2(c), respectively, shall be tolled (placed on hold) whenever the Medical Director asks a party for additional information needed to resolve the panel request. These time periods shall remain tolled until the date the Medical Director issues either a new QME panel or a decision on the panel request.

PANEL QME SPECIALTY DESIGNATIONS

According to section 30.5, the Medical Director shall utilize in the QME panel selection process the type of specialist(s) indicated by the requestor on the Request for Qualified Medical Evaluator Form 105 or 106 of Title 8 of the California Code of Regulations, unless otherwise provided in these regulations.

Under Section 31, the panels are to be randomly selected in the specialty identified by the party who has the legal right to designate the specialty.

The panel cannot include the name of any physician who has served as the primary treating physician or a secondary physician who has provided treatment to the applicant. If this situation arises, the physician is supposed to disqualify himself from the panel and either party may then request a replacement QME.

To issue a panel in a selected specialty there shall be at least five active QMEs in the specialty at the time the panel selection is requested. In the event less than five QMEs are active in a requested specialty, the Medical Director shall contact the party who holds the legal right to designate the specialty for an alternate specialty selection.

QME PANEL SELECTION DISPUTES IN REPRESENTED CASES

Section 31.1 of the new regulations deals with situations where the DWC – Medical Unit receives two or more panel requests on the same day. Section 31.1 states, in pertinent part, as follows:

(a) When the Medical Director receives two or more panel selection forms pursuant to Labor Code section 4062.2 on the same day and the forms designate different physician specialties for the QME panel, the Medical Director shall use the following procedures:

1) If one party requests the same specialty as that of the treating physician, the panel shall be issued in the specialty of the treating physician unless the Medical Director is persuaded by supporting

documentation provided by the requestor that explains the medical basis for the requested specialty;

2) If no party requests a panel in the specialty of the treating physician, the Medical Director shall select a specialty appropriate for the medical issue in dispute and issue a panel in that specialty.

3) Upon request by the Medical Director, the party requesting the panel shall provide additional medical records to assist the Medical Director in determining the appropriate specialty.

(b) In the event a party in a represented case wishes to request a QME panel pursuant to Labor Code section 4062.2 in a specialty other than the specialty of the treating physician, the party shall submit with the panel request form any relevant documentation supporting the reason for requesting a different specialty.

(c) In the event the Medical Director is unable to issue a QME panel in a represented case within thirty (30) calendar days of receiving the request, either party may seek an order from a Workers' Compensation Administrative Law Judge that a QME panel be issued. Any such order shall specify the specialty of the QME panel or the party to be designated to select the specialty.

Example:

Applicant is represented. Applicant is treating with a Chiropractor. After meeting the standards of Labor Code Section 4062.2, on the 11th day following an objection and AME proposal, both applicant's attorney and defendant file a Request for Panel QMEs. Applicant's attorney is requesting a Panel QME in the area of Pain Management. Defendants are requesting an Orthopedic Panel QME. The DWC – Medical Unit receives the Panel QME Request Forms on the same day. What Specialty will Panel QMEs be selected from?

Answer: The Panel QME will be a list of Chiropractors, unless the defendant can provide supporting documentation that explains the basis for utilizing an orthopedic specialty instead. Of course, applicant's attorney will be given the same opportunity to present supporting documentation explaining why a pain management specialist should be used.

The problem now arises, what supporting documentation is necessary to convince the DWC – Medical Unit to choose a Panel QME from a specialty other than that of the primary treating physician. Also, if the DWC – Medical Unit denies your request for a panel QME in a specialty different from the primary treating physician, is there an appeal process?

PANEL QME APPOINTMENT SCHEDULING

Section 31.3 defines the parameters for scheduling Panel QME appointments.

For unrepresented cases, the applicant has 10 days after having been furnished with the Panel QME list to select a QME from the list, schedule the appointment, and inform the claims administrator of both the QME selection and appointment. The claims administrator, employer, or any other representative of the defendant shall not discuss with the applicant whom to select from the Panel QME List.

If, within ten (10) days of the issuance of a QME panel, the unrepresented employee fails to select a QME from the QME panel or fails to schedule an appointment with the selected QME, the claims administrator may schedule an appointment with a panel QME only as provided in Labor Code section 4062.1(c), and shall notify the employee of the appointment as provided in that section.

For represented cases, once the parties have completed the striking process, the applicant has **ten business days to schedule the Panel QME.** If the applicant fails to schedule the appointment within this timeframe, then the defendant may arrange the appointment and notify the applicant and applicant's attorney.

PANEL QME REPLACEMENT REQUESTS

Section 31.5 of the new regulations addresses when a QME replacement will be issued.

A replacement QME to a panel, or at the discretion of the Medical Director a replacement of an entire panel of QMEs, shall be selected at random by the Medical Director and provided upon request whenever any of the following occurs:

(1) A QME on the panel issued does not practice in the specialty requested by the party holding the legal right to request the panel.

(2) A QME on the panel issued cannot schedule an examination for the employee within sixty (60) days of the initial request for an appointment, or if the 60 day scheduling limit has been waived pursuant to section 33(e) of Title 8 of the California Code of Regulations, the QME cannot schedule the examination within ninety (90) days of the date of the initial request for an appointment.

(3) The injured worker has changed his or her residence address since the QME panel was issued and prior to date of the initial evaluation of the injured worker.

(4) A physician on the QME panel is a member of the same group practice as defined by Labor Code section 139.3 as another QME on the panel.

(5) The QME is unavailable pursuant to section 33 (Unavailability of the QME).

(6) The evaluator who previously reported in the case is no longer available.

(7) A QME named on the panel is currently, or has been, the employee's primary treating physician or secondary physician as described in section 9785 of Title 8 of the California Code of Regulations for the injury currently in dispute.

(8) The claims administrator, or if none the employer, and the employee agree in writing, for the employee's convenience only, that a new panel may be issued in the geographic area of the employee's work place and a copy of the employee's agreement is submitted with the panel replacement request.

(9) The Medical Director, upon written request, finds good cause that a replacement QME or a replacement panel is appropriate for reasons related to the medical nature of the injury. For purposes of this subsection, "good cause" is defined as a documented medical or psychological impairment.

(10) The Medical Director, upon written request, filed with a copy of the Doctor's First Report of Occupational Injury or Illness (Form DLSR 5021 [see 8 Cal. Code Regs. §§ 14006 and 14007) and the most recent DWC Form PR-2 ("Primary Treating Physician's Progress Report" [See 8 Cal. Code Regs. § 9785.2) or narrative report filed in lieu of the PR-2, determines after a review of all appropriate records that the specialty chosen by the party holding the legal right to designate a specialty is medically or otherwise inappropriate for the disputed medical issue(s). The Medical Director may request either party to provide additional information or records necessary for the determination.

(11) The evaluator has violated section 34 (Appointment Notification and Cancellation) of Title 8 of the California Code of Regulations**,** except that the evaluator will not be replaced for this reason whenever the request for a replacement by a party is made more than fifteen (15) calendar days from either the date the party became aware of the

violation of section 34 of Title 8 of the California Code of Regulations or the date the report was served by the evaluator, whichever is earlier.

(12) The evaluator failed to meet the deadlines specified in Labor Code section 4062.5 and section 38 (Medical Evaluation Time Frames) of Title 8 of the California Code of Regulations and the party requesting the replacement objected to the report on the grounds of lateness prior to the date the evaluator served the report. A party requesting a replacement on this ground shall attach to the request for a replacement a copy of the party's objection to the untimely report.

(13) The QME has a disqualifying conflict of interest as defined in section 41.5 of Title 8 of the California Code of Regulations.

(14) The Administrative Director has issued an order pursuant to section 10164(c) of Title 8 of the California Code of Regulations (order for additional QME evaluation).

(15) The selected medical evaluator, who otherwise appears to be qualified and competent to address all disputed medical issues refuses to provide, when requested by a party or by the Medical Director, either: A) a complete medical evaluation as provided in Labor Code sections 4062.3(i) and 4062.3(j), or B) a written statement that explains why the evaluator believes he or she is not medically qualified or medically competent to address one or more issues in dispute in the case.

(16) The QME panel list was issued more than twenty four (24) months prior to the date the request for a replacement is received by the Medical Unit, and none of the QMEs on the panel list have examined the injured worker.

Whenever the Medical Director determines that a request made pursuant to subdivision 31.5(a) for a QME replacement or QME panel replacement is valid, the time limit for an unrepresented employee to select a QME and schedule an appointment under section Labor Code section 4062.1(c) and the time limit for a represented employee to strike a QME name from the QME panel under Labor Code section 4062.2(c), shall be tolled until the date the replacement QME name or QME panel is issued.

In the event the parties in a represented case have struck two QME names from a panel and subsequently a valid ground under subdivision 31.5 arises to replace the remaining QME, none of the QMEs whose names appeared on the earlier QME panel shall be included in the replacement QME panel.

OBTAINING AN ADDITIONAL QME PANEL

Section 31.7 discusses the circumstances upon which an additional Panel QME in a different specialty will be issued. Essentially, if a new issue a new medical dispute arises, the parties are to attempt to obtain a follow-up evaluation or a supplemental evaluation from the same original Panel QME, Agreed Panel QME, or AME.

Only upon a showing a good cause will a new Panel QME in a different specialty be issued. Section 31.7(b) describes good cause as meaning:

(1) An order by a Workers' Compensation Administrative Law Judge for a panel of QME physicians that also either designates a party to select the specialty or states the specialty to be selected and the residential or employment-based zip code from which to randomly select evaluators; or

(2) The AME or QME selected advises the parties and the Medical Director, or his or her designee, that she or he has completed or will complete a timely evaluation of the disputed medical issues within his or her scope of practice and areas of clinical competence but recommends that a new evaluator in another specialty is needed to evaluate one or more remaining disputed medical conditions, injuries or issues that are outside of the evaluator's areas of clinical competence, and either the injured worker is unrepresented or the parties in a represented case have been unable to select an Agreed Medical Evaluator for that purpose; or

(3) A written agreement by the parties in a represented case that there is a need for an additional comprehensive medical legal report by an evaluator in a different specialty, that attempts to select an Agreed Medical Evaluator pursuant to Labor Code section 4062.2 for that purpose have failed and the specialty that the parties have agreed upon for the additional evaluation; or

(4) In an unrepresented case, that the parties have conferred with an Information and Assistance Officer, have explained the need for an additional QME evaluator in another specialty to address disputed issues and, as noted by the Information and Assistance Officer on the panel request form, the parties have reached agreement in the presence of and with the assistance of the Officer on the specialty requested for the additional QME panel. The parties may confer with the Information and Assistance Officer in person or by conference call.

If you choose not to obtain a Panel QME in a different specialty, section 32 seems to define how the additional injuries are to be evaluated. In this regard, the original Panel QME requests a consult to evaluate the new medical dispute from a physician of his choice. The referring Panel QME must arrange the consultation appointment and advise the injured employee

and the claims administrator, or if none the employer, and each party's attorney if any, in writing of the appointment date, time and place by use of QME Form 110 (QME Appointment Notification Form)(See, 8 Cal. Code Regs. § 110).

The consulting physician shall serve the consulting report on the referring QME. Upon receipt of the consulting physician's report, the referring evaluator shall review the consulting physician's report; incorporate that report by reference into the referring evaluator's medical-legal report and comment on the consulting physician's findings and conclusions in the discussion sections of the evaluator's report.

The referring QME shall file the comprehensive medical–legal report within the time periods specified in section 38 of Title 8 of the California Code of Regulations. In the event a consulting physician's report has not been received, or will not be received, in time to comply with the time periods, the referring QME shall serve the comprehensive medical-legal report timely, and upon receipt of the consulting physician's report, the referring evaluator shall, within fifteen (15) calendar days of receipt of the consulting report, issue a supplemental report that incorporates the consulting physician's report by reference, and comments on whether and how the findings in the consulting report change the referring evaluator's opinions. The referring evaluator shall list, in the report commenting on a consulting physician's report, all reports and information received from each party for the consulting physician, indicate whether each item was forwarded to the consulting physician, and for items not forwarded the reason the referring evaluator determined it was not necessary to forward the item to the consulting physician.

With the exception of verbal communications between an injured worker and the consulting physician in the course of the consulting examination, all other communications by the parties, as well as any reports and other information from the parties for the consulting physician, if any, shall be made in writing directed only to the referring QME, who may forward such communications on to the consulting physician as appropriate. With the exception of deposing the consulting physician if necessary and except as provided in this subdivision, neither party nor a party's attorney, shall communicate directly with nor send correspondence or records directly to the consulting physician.

Pursuant to Section 32.6, The Medical Director shall issue a panel of Qualified Medical Evaluators upon receipt of an order of a Workers' Compensation Administrative Law Judge or the Appeals Board, that includes a finding that an additional evaluation is reasonable and necessary to resolve disputed issues under Labor Code sections 4060, 4061 or 4062.

The order shall specify the residential or employment-based zip code from which to randomly select evaluators, specify the specialty for the QME panel or designate the party who shall select the specialty of the QME panel, and specify who shall select a new specialty in the event there are too few QMEs in the specialty initially selected to issue a panel in accordance with section 31(d) of Title 8 of the California Code of Regulations.

PANEL QME APPOINTMENTS

Section 33 discusses Panel QME appointment timeframes. Under this section, if a party cannot obtain a Panel QME appointment with the selected Panel QME within sixty (60) days of the date of the appointment request, that party may request a replacement Panel QME.

On the other hand, any party may waive the right to a replacement in order to accept an appointment no more than ninety (90) days after the date of the party's initial appointment request. When the selected QME is unable to schedule the evaluation within ninety (90) days of the date of that party's initial appointment request, either party may report the unavailability of the QME and the Medical Director shall issue a replacement pursuant to section 31.5 of Title 8 of the California Code of Regulations upon request, unless both parties agree in writing to waive the ninety (90) day time limit for scheduling the initial evaluation.

PANEL QME APPOINTMENT NOTIFICATION AND CANCELLATION

Section 34 states that when a Panel QME appointment is scheduled, the Panel QME is required to complete an appointment notification form by submitting the form in Section 110 (QME Appointment Notification Form)(See, 8 Cal. Code Regs. § 110). The completed form shall be postmarked or sent by facsimile to the employee and the claims administrator, or if none the employer, within 5 business days of the date the appointment was made. In a represented case, a copy of the completed form shall also be sent to the attorney who represents each party, if known. Failure to comply with this requirement shall constitute grounds for denial of physician for QME reappointment under section 51 of Title 8 of the California Code of Regulations.

The Panel QME appointment shall be conducted only at the medical office listed on the panel selection form. However, upon written request by the injured worker and only for his or her convenience, the evaluation appointment may be moved to another medical office of the selected QME if it is listed with the Medical Director as an additional office location.

The QME shall include within the notification whether a Certified Interpreter, as defined by Labor Code Section 5811 and subject to the provisions of section 9795.3 of Title 8 of the California Code of Regulations, is required and specify the language. The interpreter shall be arranged by the party who is to pay the cost as provided for in Section 5811 of the Labor Code.

In terms of cancellations, section 34(d) states that an evaluator, whether an AME, Agreed Panel QME or QME, shall not cancel a scheduled appointment less than six (6) business days prior to the appointment date, except for good cause. Whenever an evaluator cancels a scheduled appointment, the evaluator shall advise the parties in writing of the reason for the

cancellation. The Appeals Board shall retain jurisdiction to resolve disputes among the parties regarding whether an appointment cancellation pursuant to this subdivision was for good cause. The Administrative Director shall retain jurisdiction to take appropriate disciplinary action against any Agreed Panel QME or QME for violations of this section.

An Agreed Panel QME or a QME who cancels a scheduled appointment shall reschedule the appointment to a date within thirty (30) calendar days of the date of cancellation. The re-scheduled appointment date may not be more than sixty (60) calendar days from the date of the initial request for an appointment, unless the parties agree in writing to accept the date beyond the sixty (60) day limit.

An Agreed Medical Evaluator who cancels a scheduled appointment shall reschedule the appointment within sixty (60) calendar days of the date of the cancellation, unless the parties agree in writing to accept an appointment date no more than thirty (30) calendar days beyond the sixty (60) day limit.

Failure to receive relevant medical records, as provided in section 35 of Title 8 of the California Code of Regulations and section 4062.3 of the Labor Code, prior to a scheduled appointment shall not constitute good cause under this section for the evaluator to cancel the appointment, unless the evaluator is a psychiatrist or psychologist performing an evaluation regarding a disputed injury to the psyche who states in the evaluation report that receipt of relevant medical records prior to the evaluation was necessary to conduct a full and fair evaluation.

Section 34(h) provides that when a party cancels an AME, Agreed Panel QME, or Panel QME, this appointment shall not be cancelled or rescheduled by a party or the party's attorney less than six (6) business days before the appointment date, except for good cause. Whenever the claims administrator, or if none the employer, or the injured worker, or either party's attorney, cancels an appointment scheduled by an evaluator, the cancellation shall be made in writing, state the reason for the cancellation and be served on the opposing party. Oral cancellations shall be followed with a written confirming letter that is faxed or mailed by first class U.S. mail within twenty four hours of the verbal cancellation and that complies with this section. An injured worker shall not be liable for any missed appointment fee whenever an appointment is cancelled for good cause. The Appeals Board shall retain jurisdiction to resolve disputes regarding whether an appointment cancellation by a party pursuant to this subdivision was for good cause.

The date of cancellation shall be determined from the date of postmark, if mailed, or from the facsimile receipt date as shown on the recipient's fax copy.

COMMUNICATIONS WITH PANEL QME

Section 35 describes the process for communicating with a Panel QME and determines what information can be sent to the Panel QME. Basically, ex parte communications, i.e. communications without the other parties knowledge, are strictly prohibited.

Second, section 35(c) requires that at least 20 days before information is provided to the QME, any party wishing to submit medical and non-medical records and information shall serve it on the opposing party. In both unrepresented and represented cases, the claims administrator shall attach a log to the front of the records and information being sent to the evaluator and list each item in the order it is attached to or appears on the log. In a represented case, the applicant's attorney shall do the same for any records or other information they want to send to the evaluator.

Also, the claims administrator must include a cover letter or other document when providing such information to the applicant, which shall clearly and conspicuously include the following language:

> "Please look carefully at the enclosed information. It may be used by the doctor who is evaluating your medical condition as it relates to your workers' compensation claim. If you do not want the doctor to see this information, you must let me know within 10 days."

Under Section 35(d), if the opposing party objects within 10 days to any non-medical records or information proposed to be sent to the evaluator, those records and that information shall not be provided to the evaluator, unless ordered by a WCALJ.

Section 35(a) confirms the type of information an applicant or defendant can provide to an AME, Agreed panel QME or QME. These include:

(1) All records prepared or maintained by the employee's treating physician or physicians;

(2) Other medical records, including any previous treatment records or information, which are relevant to determination of the medical issue(s) in dispute;

(3) A letter outlining the issues that the evaluator is requested to address in the evaluation, which shall be served on the opposing party no less than 20 days in advance of the evaluation~~.~~ ;

(4) Whenever the treating physician's recommended medical treatment is disputed, a copy of the treating physician's report recommending the medical treatment with all supporting documents, a copy of claims administrator's, or if none the employer's, decision to approve, delay, deny or modify the disputed treatment with the documents supporting the decision, and all other relevant communications about the disputed treatment exchanged during the utilization review process required by Labor Code section 4610;

(5) Non-medical records, including films and videotapes, which are relevant to determination of medical issue(s) in dispute, after compliance with subdivision 35(c) of Title 8 of the California Code of Regulations.

Represented parties who have selected an Agreed Medical Evaluator or an Agreed Panel QME shall, as part of their agreement, agree on what information is to be provided to the AME or the Agreed Panel QME, respectively.

Under Section 35(e), in no event shall any party forward to the evaluator:

(1) any medical/legal report which has been rejected by a party as untimely pursuant to Labor Code section 4062.5;

(2) any evaluation or consulting report written by any physician other than a treating physician, the primary treating physician or secondary physician, or an evaluator through the medical-legal process in Labor Code sections 4060 through 4062, that addresses permanent impairment, permanent disability or apportionment under California workers' compensation laws, unless that physician's report has first been ruled admissible by a Workers' Compensation Administrative Law Judge; or

(3) any medical report or record or other information or thing which has been stricken, or found inadequate or inadmissible by a Workers' Compensation Administrative Law Judge, or which otherwise has been deemed inadmissible to the evaluator as a matter of law.

Copies of all records being sent to the evaluator shall be sent to all parties except as otherwise provided in section (d) and (e). Failure to do so shall constitute ex parte communication within the meaning of subdivision (k) below by the party transmitting the information to the evaluator.

In the event that the unrepresented employee schedules an appointment within 20 days of receipt of the panel, the employer or if none, the claims administrator shall not be required to comply with the 20 day time frame for sending medical information in subsection (c) provided, however, that the unrepresented employee is served all non-medical information in subdivision (c) 20 days prior to the information being served on the QME so the employee has an opportunity to object to any non-medical information.

In the event that a party fails to provide to the evaluator any relevant medical record which the evaluator deems necessary to perform a comprehensive medical-legal evaluation, the evaluator may contact the treating physician or other health care provider, to obtain such record(s). If the party fails to provide relevant medical records within 10 days after the date of the evaluation, and the evaluator is unable to obtain the records, the evaluator shall complete and serve the report to comply with the statutory time frames under section 38 of Title 8 of the California Code of Regulations. The evaluator shall note in the report that the records were not received within the required time period. Upon request by a party, or the Appeals Board, the evaluator shall complete a supplemental evaluation when the relevant medical records are received. For a supplemental report the evaluator need not conduct an additional physical examination of the employee if the evaluator believes a review of the additional records is sufficient.

Under Section 35(j) the evaluator and the employee's treating physician(s) may consult as necessary to produce a complete and accurate report. The evaluator shall note within the report new or additional information received from the treating physician.

Under Section 35(k) the Appeals Board shall retain jurisdiction in all cases to determine disputes arising from objections and whether ex parte contact in violation of Labor Code section 4062.3 or this section of Title 8 of the California Code of Regulations has occurred. **If any party communicates with an evaluator in violation of Labor Code section 4062.3, the Medical Director shall provide the aggrieved party with a new panel in which to select a new QME or the aggrieved party may elect to proceed with the original evaluator.** Oral or written communications by the employee, or if the employee is deceased by the employee's dependent, made in the course of the examination or made at the request of the evaluator in connection with the examination shall not provide grounds for a new evaluator unless the Appeals Board has made a specific finding of an impermissible ex parte communication.

NEED FOR ADDITIONAL PANEL QME

Under Section 35.5(d) at the evaluator's earliest opportunity and no later than the date the report is served, the evaluator shall advise the parties in writing of any disputed medical issues outside of the evaluator's scope of practice and area of clinical competency in order that the

parties may initiate the process for obtaining an additional evaluation pursuant to section 4062.1 or 4062.2 of the Labor Code and these regulations in another specialty.

In the case of an Agreed Panel QME or a panel QME, the evaluator shall send a copy of the written notification provided to the parties to the Medical Director at the same time. However, only a party's request for an additional panel, with the evaluator's written notice under this section attached, or an order by a Workers' Compensation Administrative Law Judge, will be acted upon by the Medical Director to issue a new QME panel in another specialty in the claim.

Section 35.5(e) states that in the event a new injury or illness is claimed involving the same type of body part or body system and the parties are the same, or in the event either party objects to any new medical issue within the evaluator's scope of practice and clinical competence, the parties shall utilize to the extent possible the same evaluator who reported previously.

Section 35.5(f) states that a Panel QME or Evaluator shall make himself or herself available for deposition within at least one hundred twenty (120) days of the notice of deposition.

SERVICE OF COMPREHENSIVE MEDICAL-LEGAL EVALUATION REPORTS

Section 36 describes an evaluator's service requirements. For claims administrators, the most relevant portion of this section is subsection (d). This subsection states, in pertinent part,

> "After a Qualified Medical Evaluator has served a comprehensive medical-legal report that finds and describes permanent impairment, permanent disability or apportionment in the case of an unrepresented injured worker, the QME shall not issue any supplemental report on any of those issues in response to a party's request until after the Disability Evaluation Unit has issued an initial summary rating report, or unless the evaluator is otherwise directed to issue a supplemental report by the Disability Evaluation Unit, by the Administrative Director or by a Workers' Compensation Administrative Law Judge. A party wishing to request a supplemental report pursuant to subdivision 10160(f) of Title 8 of the California Code of Regulations, based on the party's objection to or need for clarification of the evaluator's discussion of permanent impairment, permanent disability or apportionment, may do so only by sending the detailed request, within the time limits of subdivision 10160(f), directly to the DEU office where the report was served by the evaluator and not to the evaluator until after the initial summary rating has been issued.

So in those situations where you have an unrepresented applicant, and a Panel QME issues a Permanent and Stationary report, the parties cannot obtain a supplemental report from the QME on the issues of permanent impairment or disability and apportionment until after the DEU has issued an initial summary rating report, or unless the DEU, Administrative Director or WCALJ requests the supplemental report.

MEDICAL EVALUATION TIME FRAMES AND EXTENSIONS

Section 38 defines reporting time frames for QMEs and AMEs.

Under section 38(a), a Panel QME, Agreed Panel QME and AME an initial or follow up report has to be prepared and submitted no later than 30 days after the examination. If the evaluator fails to do so, and does not obtain an extension from the Medical Director, either party may request a QME replacement. Neither the employee nor the employer shall have any liability for payment for the medical evaluation which was not completed within the timeframes required under this section unless the employee and the employer each waive the right to a new evaluation and elect to accept the original evaluation, in writing or by signing and returning to the Medical Director either QME Form 113 (Notice of Denial of Request For Time Extension) or QME Form 116 (Notice of Late QME/AME Report – No Extension Requested) (See, 8 Cal. Code Regs. §§ 113 and 116).

All requests by an evaluator for extensions of time shall be made on Form 112 (QME/AME Time Frame Extension Request) (See, 8 Cal. Code Regs. § 112). If the evaluation will not be completed on the original due date, the evaluator may request an extension from the Medical Director, not to exceed an additional 30 days. An extension of the time for completing the report shall be approved, as follows:

When the evaluator has not received test results or the report of a consulting physician, necessary to address all disputed medical issues in time to meet the initial 30-day deadline, an extension of up to thirty (30) days shall be granted.

When the evaluator has good cause, as defined in Labor Code section 139.2(j)(1)(B), an extension of fifteen (15) days shall be granted.

Not later than 5 days before the initial 30-day period to complete and serve the report expires, the evaluator shall notify the Medical Director, the employee and the claims administrator, or if none, the employer, of the request for an extension by use of QME Form 112 (QME/AME Time Extension Request) (See, 8 Cal. Code Regs. § 112).

The Medical Director shall notify the requesting evaluator and the parties of the decision on the extension request by completion of the box at the bottom of QME Form 112 (QME/AME Time Frame Extension Request)(See, 8 Cal. Code Regs. § 112). In the event that a request for an extension of time is denied, the Medical Director shall also send the parties QME Form 113 (Notice of Denial of Request for Time Extension)(See, 8 Cal. Code Regs. § 113) to be used by each party to state whether the party wishes to request a new evaluator or to accept the late report of the original evaluator.

Whenever the Medical Director becomes aware that the report of a Qualified Medical Evaluator or an Agreed Medical Evaluator has not been completed within the required time under section 38 and no extension of time was requested by the evaluator, the Medical Director shall send the parties a Notice of Late QME/AME Report – No Extension Requested (QME Form 116) (See, 8 Cal. Code Regs. § 116). Each party shall complete the form and return it to the Medical Director in order to indicate whether or not the party wishes to accept the late report.

Good cause, as defined in Labor Code section 139.2(j)(1)(B) and section 38(b)(2) of Title 8 of the California Code of Regulations, means:

(1) medical emergencies of the evaluator or the evaluator's family;

(2) death in the evaluator's family;

(3) natural disasters or other community catastrophes that interrupt the operation of the evaluator's office operations;

Extensions shall not be granted because relevant medical information/records (including Disability Evaluation Form 101 (Request for Summary Determination of Qualified Medical Evaluator's Report) (See, 8 Cal. Code Regs. § 10161) have not been received. The evaluator shall complete the report based on the information available and state that the opinions and/or conclusions may or may not change after review of the relevant medical information/records.

The time frame for supplemental reports shall be no more than sixty (60) days from the date of a written or electronically transmitted request to the physician by a party. The request for a supplemental report shall be accompanied by any new medical records that were unavailable to the evaluator at the time of the original evaluation and which were properly served on the opposing party as required by Labor Code section 4062.3. An extension of the sixty (60) day time frame for completing the supplemental report, of no more than thirty (30) days, may be agreed to by the parties without the need to request an extension from the Medical Director.

Evaluators requesting time extensions will be monitored and advised by the Medical Director when such a request appears unreasonable or excessive. Failure to comply with this section may constitute grounds for denial of the QME's request for reappointment pursuant to section 51 of Title 8 of the California Code of Regulations.

L.C. §4658 (d) RETURN TO WORK

AKA (+-15%) BUMP UP OR BUMP DOWN OF PD

THE BASICS

A. Labor Code Section 4658(d)

1. 4658(d)(2): Within sixty days of a disability becoming permanent and stationary, and should an employer not offer the injured employee regular work, modified work, or alternative work, in the form and manner prescribed by the Administrative Director, for a period of at least twelve months, each disability payment remaining to be paid from the date of the end of the sixty day period shall be increased by fifteen percent. This does not apply to an employer with fewer than fifty employees.

2. 4658(d)(3)(A): Within sixty days of a disability becoming permanent and stationary, an employer that offers an injured employee regular work, modified work, or alternative work, in the form and manner prescribed by the Administrative Director, for a period of at least twelve months, regardless of whether the injured worker accepts or rejects said offer, generates a right to reduce each disability payment remaining to be paid by fifteen percent.

3. (B) If either regular, modified or alternative work is terminated by the employer prior to the end of the period for which disability payments are due, the amount of each of the remaining disability payments shall again be increased by fifteen percent. However, an employee who voluntarily terminates employment is not eligible for payment under this Section. Not applicable to employers employing fewer than fifty employees.

PRACTICE POINTERS

- APPLIES TO DOI'S 1/1/05-PRESENT
- Decrease/increase of 15% only applies to those PD checks that remain to be issued, NOT TO ENTIRE AMOUNT OF PD
- Increase begins 60 days from P&S date
- Decrease begins at time that the proper offer was made
- Increase only applies to employers with 50 or more employees
- Decrease applies to all employers regardless of number of EE's

WHAT IS REGULAR, MODIFIED OR ALTERNATIVE WORK?

A. Regular work (original job)- Use form DWC-AD 10003

Defined as the employee's usual occupation or position in which said worker was engaged at the time of injury and which offers wages and compensation equivalent to those paid to the Applicant at the time of the injury, and located within a reasonable commuting distance of the employee's residence at the time of injury.

B. Modified work (original job, but duties changed)- Use DWC-AD 10133.53

Work that is modified so that the Applicant has the ability to perform all of the functions of said job and which offers wages and **compensation that is at least eighty-five percent** of those paid to the employee at the time of injury, and located within a reasonable commuting distance of the employee's residence at the time of injury.

C. Alternative work (different job)- Use DWC-AD 10133.53

Refers to work that the Applicant has the ability to perform, that offers wages and compensation at least eighty-five percent of those paid at the time of injury, and work that is located within reasonable commuting distance of the employee's residence at the time of injury.

PRACTICE POINTERS

- Applicant has 20 days to respond to regular work offer
- Applicant has 30 days to respond to mod/alt offer
- Cannot use offer of extra hours to meet compensation requirement.
- Still have to serve form even if Applicant returns to work beforehand.
- Reasonable distance is determined by Applicant's residence at the time of injury so that if Applicant moves you do not have to find a job in his new area.
- Offer must be for 12 months of work. If the job ends beforehand then 15% bump up applies unless Applicant quit.
- Applicant has 20 calendar days to object to a distance as not reasonable

REMAINING QUESTIONS

- Which report controls? (MPN Dr., QME, PTP)
- What if P&S date is found retroactively by doctor? Is the 60 day period tolled?
- What if job ends before 12 months, but no benefits left?

DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK

For injuries occurring on or after 1/1/04

THIS SECTION COMPLETED BY EMPLOYER OR CLAIMS ADMINISTRATOR:

Employer (name of firm) ______________________ is offering you the position of a

(name of job) ______________________.

Attach a list of the duties required of the position.

You may contact ______________________ concerning this offer. Phone No.: ______________

Date of offer: ______________________. Date job starts: ______________________.

Claims Administrator: ______________________ Claim Number: ______________

NOTICE TO EMPLOYEE Name of employee: ______________________

Date offer received: ______________________

You have 30 calendar days from receipt to accept or reject this offer of modified or alternative work. If you reject this job offer, you will not be entitled to the supplemental job displacement benefit unless:

Modified Work

A. The proposed modification(s) to accommodate required work restrictions are inadequate.
B. The modified job will not last 12 months.

Alternative Work

A. You cannot perform the essential functions of the job; or
B. The job is not a regular position lasting at least 12 months; or
C. Wages and compensation offered were less than 85% paid at the time of injury; or
D. The job is beyond a reasonable commuting distance from residence at time of injury.

THIS SECTION TO BE COMPLETED BY EMPLOYEE

___ I accept this offer of Modified or Alternative work.

___ I reject this offer of Modified or Alternative work and understand that I am not entitled to supplemental job displacement benefit.

______________________ Date ______________________

Signature

I feel I cannot accept this offer because:

NOTICE TO THE PARTIES

If the offer is <u>not</u> accepted or rejected within 30 days of the offer, the offer is deemed to be rejected by the employee.

The employer or claims administrator must forward a completed copy of this agreement to the Administrative Director within 30 days of acceptance or rejection.
If a dispute occurs regarding the above offer or agreement, either party may request the Administrative Director to resolve the dispute by filing a Request for Dispute Resolution (Form DWC-AD-10133.54) with the Administrative Director.

MANDATORY FORMAT
STATE OF CALIFORNIA
Draft 01/27/04

DWC-AD 10003 NOTICE OF OFFER OF REGULAR WORK

For injuries occurring on or after 1/1/05

THIS SECTION TO BE COMPLETED BY EMPLOYER OR CLAIMS ADMINISTRATOR:

Claims Administrator:________________________________ Claim Number:________________
(Name of Claims Administrator)

Based on the opinion of ___treating physician___QME___AME________________, you are able to return to
(Name of Physician)

your usual occupation or the position you held at the time of your injury on____________________.
(Date)

Date you are eligible to return to job:____________________(as stated in the above physician's report)

Employer:______________________________
(Name of Firm)

Job Title:______________________________

Starting Date:______________________________

__ This position is at the same location and shift as your pre-injury position.

__ This position is at a different location than your pre-injury position, as follows:____________________

____

__ This position is for a different shift than your pre-injury position, as follows:____________________
(start time) (end time)

You may contact ________________________concerning this position. Phone No.:______________
(Name of Contact Person)

You must return the completed form to the employer or claims administrator listed here:

____
(Name of Employer or Claims Administrator) (Mailing address)

This position is expected to last for a total of at least 12 months of work. If this position does not last for a total of at least 12 months of work, you may be entitled to an increase in your permanent disability benefit payments.

This position provides wages and compensation of $____________________, that are equivalent to or more than the wages and compensation paid to you at the time of your injury.

I,______________________________, have obtained the above job offer information from your employer.
(Name of Claims Administrator)

If the job offered is at a different location than the job you held at the time of your injury, and you believe the commuting distance to this job from the residence where you lived at the time of your injury is not reasonable, you may object to the job offer as not being within a reasonable commuting distance. You may also waive this commuting distance requirement. You will be considered to have waived this requirement if you accept the above offer of work or do not reject the offer within twenty calendar days of receipt of this notice.

THIS SECTION TO BE COMPLETED BY EMPLOYEE: **Claim Number**________________

The employee must accept, reject, or object to this offer for regular work and return this form to the employer or claims administrator listed on page one within 20 calendar days of receipt of the offer or it will be deemed that the employee has waived the right to object to the location or shift. The employee should keep a copy of this form for his or her records.

Name of employee:____________________________ Date offer received:____________________

I understand that if my disability is permanent and stationary and the employer has fulfilled its legal obligations related to this offer, my remaining permanent disability payments will be decreased by 15% whether I accept or reject this offer.

Offer of Regular Work at Same Location and/or Shift

__ I accept this offer of regular work.

__ I reject this offer of work. Reason:____

Note: If either party has a dispute or objection regarding the offer of regular work, or if the employee rejects the offer of regular work, that party may file a Declaration of Readiness with the local district office of the Workers' Compensation Appeals Board (WCAB).

Offer of Regular Work at a Different Location and/or Shift

I understand that I have the right to object to a work offer when the location or shift is different than what I had at the time of my injury.

__ I accept the offer and waive my right to object to the job location or shift as not being within a reasonable commuting distance from the residence where I lived at the time of my injury.

__ I reject this offer of work. Reason: ____

__ I object to this offer because the job location that has been offered is different than the job location I held at the time of my injury, and I do not believe this job allows a reasonable commute from my residence. I understand if the claims administrator does not agree with this objection, my remaining permanent disability weekly benefit payment may be decreased by 15%.

__ I object to this offer because the job shift that has been offered is different than the job shift I held at the time of my injury. I understand if the claims administrator does not agree with this objection, my remaining permanent disability weekly benefit payment may be decreased by 15%.

Note: If either party has a dispute or objection regarding the offer of regular work, or if the employee rejects the offer of regular work, that party may file a Declaration of Readiness with the local district office of the Workers' Compensation Appeals Board (WCAB).

______________________________________ Date: ____________________

Signature

Proof of Service By Mail or Hand Delivery

I am a resident of the County of ______________________________. I am over the age of eighteen years and not a party to the within matter. My business address is:

____.

On ______________________________, I served the **Notice of Offer of Regular Work** on the party/parties listed below by either method of service described below:

A. Placing a true copy of the **Notice of Offer of Regular Work** in a sealed envelope with postage fully prepaid addressed to each person whose name and address is given below by depositing the envelope in the United States mail.

Or

B. Personally serving a true copy of the **Notice of Offer of Regular Work** on each person whose name and address is given below.

Enter the name of the party and indicate the type of service in the box (either A or B as described above.)

Name of Party:	Type of Service
______________________________	☐
______________________________	☐
______________________________	☐
______________________________	☐

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed at

______________________________ on ______________________________.

Signature:______________________________