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THE DOWNSIDE OF DENIAL

There is an old joke where the schoolboy is asked to use “denial” in a sentence and he responds, “Denial is a river in Egypt.” In Workers’ Compensation, the denial is definitely not a river, but if not properly timed and exercised, a denial can leave the adjuster with a flood of problems later in the case. We believe there are a number of factors that should be considered before deciding whether to issue a denial of compensability, and when to issue it.

DENIAL BASICS

Denials of all compensability for a claimed injury need to occur within the first 90 days after presentation of the completed claim form. With rare exception, failure to issue a denial within the prescribed time mandates that the case is presumptively compensable, leaving the defendant with the option of disputing nature and extent of injury, but not the fact that is compensable under the Labor Code. *LC 5402(b)*. In addition, the duty to provide the claim form runs from the date the employer has knowledge from any source whatsoever. *LC 5402(a)*.

As a separate matter, and distinct from the general topic of this article, an injury may be accepted while certain claimed disabilities from the injury may be denied. There is no presumption that attaches to any claimed disability when the fact of the injury is admitted. Disputes over parts of the body and disabilities claimed go to nature and extent of injury. Failure to issue a denial of a claimed body part while admitting others does not invoke any kind of presumption against the defendant in a litigated case. *Clark v WCAB* (2001) 66 CCC 269 (writ denied)

Denials of all compensability for a claimed injury may be based on legal issues such as alleged lack of WCAB jurisdiction, lack of an employment relationship, and affirmative legal defenses such as the “post termination claim,” intoxication, or a host of other statutorily created exceptions to what would otherwise be a compensable claim. Denials may also be based on medical evidence indicating that the cause of a claimed disability is not, in reality, a work injury.

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THE EFFECT OF A DENIAL OF ALL LIABILITY

Assuming there is some substantial basis for issuing a complete denial of liability for a claimed injury, the issuance of the denial cuts off liability for medical treatment, which is otherwise payable up to the first \$10,000 while the claim is being investigated. *LC 5402(c)*. However, there are downsides as well, including discovery limitations and substantial future economic risks should there be a later determination that benefits must be provided.

THE DISCOVERY PROBLEM

Issuing a denial of all compensability for a claim immediately limits the discovery options available to the adjuster. For example, in a case where determination of compensability requires medical expertise, the issuance of a denial precludes the adjuster from requesting a PQME assignment pursuant to LC 4060. *8 Cal. Reg. 30(d)(3)*. The applicant, however, can procure treatment with any doctor or medical group that will willingly run up tens of thousands of dollars of treatment costs on a lien basis. In such a case, the treating doctors will most assuredly make a case for compensability and counsel representing the injured worker may legally forego a request for a PQME, opting instead to either let the self-procured medical treatment run its course or, in the alternative, file for an Expedited Hearing limiting the medical evidence to the reports of the self procured doctor's reports.

In addition to the LC 4060 problem noted above, denial of all compensability releases the injured worker from having to limit treatment to doctors within a designated MPN. *Braewood Convalescent Hospital v. WCAB* (1983), 48 CCC 566.

Issuing denials without a solid evidentiary basis at the time the case is denied may subject the adjuster to penalties for bad faith denial. Labor Code 5814 provides for penalties payable to the injured worker for up to 25% of the amount delayed, up to \$10,000. A separate 10% penalty must be added to any periodic indemnity payments that should have been made absent the unsupported denial. LC 4650(d). In addition, the 104 week cap for temporary disability does not begin to run even when EDD has been paying benefits in the interim. Finally, if there has been an increase in indemnity rates between the time the case is denied and the time it is determined temporary disability must be paid, all the retroactive temporary disability due must be paid at the new, higher rate.

Audit penalties for failure to have appropriate documentation in the claims file supporting the denial are specified in 8 Cal. Reg. 10111.1(d)(1) and can be up to \$5,000 for each occurrence. The proper test is whether, at the time the denial is issued, there is documented evidence of some substantiality in the claims file that would cast a reasonable doubt as to whether the matter is compensable at all. Evidence is different from rumor, speculation, or conjecture. Evidence is not, as we tend so often to see, a knee-jerk reaction that "We don't normally accept those types of claims." For a more in-depth discussion of what constitutes substantial evidence, go to www.mcdermott-clawson.com, click on "recent events" and see the April, 2007 edition of *Legal Briefs*.

Failure of the injured worker to accompany the claim with evidence supporting it is not, in and of itself, a basis for denial. The law imposes a duty on the defendant to investigate the claim before making a determination. *8 Cal. Reg. 10109*. This duty is so specifically set forth in the rule, it is worth reprinting verbatim:

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- (a) To comply with the time requirements of the Labor Code and the Administrative Director's regulations, a claims administrator must conduct a reasonable and timely investigation upon receiving notice or knowledge of an injury or claim for a workers' compensation benefit.
- (b) A reasonable investigation must attempt to obtain the information needed to determine and timely provide each benefit, if any, which may be due the employee.
- (1) The administrator may not restrict its investigation to preparing objections or defenses to a claim, but must fully and fairly gather the pertinent information, whether that information requires or excuses benefit payment. The investigation must supply the information needed to provide timely benefits and to document for audit the administrator's basis for its claims decisions. The claimant's burden of proof before the Appeal Board does not excuse the administrator's duty to investigate the claim.
- (2) The claims administrator may not restrict its investigation to the specific benefit claimed if the nature of the claim suggests that other benefits might also be due.
- (c) The duty to investigate requires further investigation if the claims administrator receives later information, not covered in an earlier investigation, which might affect benefits due.
- (d) The claims administrator must document in its claim file the investigatory acts undertaken and the information obtained as a result of the

investigation.

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

A RECOMMENDED APPROACH

As discussed above, the claims examiner has a positive duty to investigate the claim. This is both a duty, and an opportunity. Early investigation is potentially a good means to avoid costly mistakes in deciding either to admit or deny a claim. The Labor Code gives the adjuster 90 days to attempt to get enough information to make a good determination, with documentation, as to whether a case should be denied. Although, as earlier stated, the period of delay does bring with it liability for medical treatment during the period of delay, in most cases the dollar value of that treatment will be considerably less than the ultimate liability for a case that should have been accepted but was inappropriately denied.

Communication with the employer is very important. Statements from supervisors or co-workers may provide sufficient documentation to support a denial. On the other hand, they may shed further light on facts which support admitting the claim and taking control of it. If it appears, from initial employer contact, that there are witnesses who can shed light on the facts of the case either way, an investigator should be assigned to take statements as soon as possible. We recommend that reports of investigators be undertaken for, and addressed to, counsel as this may protect them from unwanted discovery as attorney work product.

If the case is litigated (and most denied and deniable claims tend to be), consider an early referral to counsel. This is especially true when the denial is going to be on a legal basis (such as an affirmative or other statutory defense).

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Experienced counsel can evaluate the available facts in light of the applicable law, which sometimes is complex with nuances and exceptions, and provide the adjuster an objective analysis of the ultimate chances for success in defending compensability of the claim.

Consider an early deposition. Although this writer has only once in 30 years been told something in a deposition that supported an immediate denial (the claimant stated she was not injured, never intended to make a claim and did not give her attorney authority to do so), information obtained in a deposition often leads to discoverable evidence either supporting the claim or supporting its denial.

There are many cases where the question of compensability depends on medical opinion. As noted earlier, once the adjuster denies the claim, the ability to request a panel QME under LC 4060 is lost, except to the injured worker. When the request for the panel assignment is made, one of the threshold questions on the prescribed form asks whether the case has been denied. If the case is still under delay when the request is made, a panel can be assigned. There is nothing we find in the rules that precludes a denial from issuing (assuming there is substantial documentation supporting it) *after* the request for a panel assignment is submitted to the DWC, but before the panel QME exam actually takes place.

Remember, also, that LC 4061 and LC 4062 remain available in those instances where a dispute may be raised as to parts of the body injured, MMI status, and nature and extent of permanent disability. Once a QME or AME is assigned to evaluate the case, that doctor is required to weigh in on *all issues*, including injury AOE/COE. *LC 4062.3(i)*.

Article by Howard Stevens, Orange Office

NEW CASE LAW ON 6/11/09:

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THE VOCATIONAL REHAB QUESTION

The Workers' Compensation Appeals Board ruled in an *en banc* decision in the case of [Weiner v Ralph's](#) issued 6/11/09 that the repeal of California's vocational rehabilitation statute terminated any rights to benefits or services that were not ordered or awarded before Jan. 1, 2009.

Since this is an *en banc* decision of all the Commissioners of the WCAB, all trial judges are bound by the decision even pending attempts to take the matter to the Court of Appeal.

It should also be noted that the question is actually already before the Court of Appeal in another case. The Second District Appellate Court recently granted a defense petition for a writ of review in the case of *Beverly Hilton Hotel v. WCAB* involving the same or similar questions: Does the WCAB have any jurisdiction to grant Vocational Rehabilitation in light of the sunset provisions which repealed LC 139.5 and its statutory kinfolk? However, as noted, for now the rule is, there is no such thing as Vocational Rehabilitation.

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