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CASES & COMMENTS ON WORKERS' COMPENSATION

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THINGS TO KNOW FOR 2012

Get Out Your Checkbooks

Hard times notwithstanding, the State Average Minimum Wage has again increased, mandating an increase in weekly Life Pension rates, Temporary Disability rates and 100% Permanent Total Disability payments beginning January 1st, 2012, applying the rules as laid out in *Christine Baker vs. Workers Compensation Appeals Board*, 52 Cal. 4th 434, 76 Cal. Comp. Cases 701. A 2.4% increase is mandated because California Labor Code Section 4453(a)(10) requires the rate for TTD benefits to be increased by an amount equal to the percentage increase in the state's average weekly wage. California's average weekly wage for the 12 months ending March 31, 2011, was \$1,003.55, up from \$979.90 for 2010

Maximum and minimum temporary total disability (TTD) benefit payments will increase in 2012 because of this increase in the state's average weekly wage. Maximum

weekly TTD benefits will need to be increased to \$1,010.50 from the current \$986.69. Minimum TTD benefits will increase to \$151.57 from \$148.

You will also have to increase payments to workers who are receiving life pension or permanent total disability benefits with dates of injury on or after Jan. 1, 2003, as they are also entitled to have their weekly benefit increased 2.4% based on the state's average weekly wage.

Starting the COLA Increases

When different District Courts of Appeal come up with different rulings on the same issue, you can be fairly certain that the State Supreme Court will have to weigh in as the final arbiter of the dispute. Such was the case when the Supreme Court issued its decision August 11th in the case of *Baker* case (supra).

Los Angeles
16530 Ventura Boulevard, Suite 209
Encino, CA 91436
(818) 997-2100

Orange County / Inland Empire
1700 West Katella Avenue
Orange, CA 92867
(714) 288-1700

The dispute was about *when* to begin compounding the increases in pension payments. To receive the benefit of a cost of living adjustment on any given January 1st, a worker who has sustained an industrial injury must meet two conditions.

First, he or she must have been injured on or after January 1, 2003. Second, he or she must become entitled to receive a life pension or total permanent disability indemnity. Lab. Code, § 4659 (c).

The entitlement to total permanent disability indemnity payments arises when the injured worker's condition becomes permanent and stationary, said the Court. By contrast, in the case of life pension benefits, the entitlement to receive such payments arises by statute when the worker's partial permanent disability benefits have been exhausted. Labor Code § 4659 (a).

It is not until the injured employee becomes entitled to receive a life pension or total permanent disability indemnity, and actually begins receiving such payments, that he or she shall have that payment increased annually by an amount equal to the percentage increase in the state average weekly wage as compared to the prior year. By the terms of the statute, the increases kick in as of the January 1st following the entitlement event (as previously described).

UR Denials Require AME/QME Process

At least, so says a WCAB panel in a recently publicized decision in *Willis v. Waste Management*. The panel decision holds that applicants wishing to litigate a utilization

review denial of medical treatment must follow the panel qualified medical evaluator process described in Labor Code § 4062, according to the report of the Workers' Compensation Appeals Board's decision

The three-member panel analyzed Labor Code §§ 4062, 4610, and also specific language from the *SCIF v. WCAB* (Sandhagen) decision. The panel declared. "If (the LC 4062) process does not lead to the resolution of the dispute, it may then be presented to a workers' compensation judge for determination. By following the Section 4062 process, the workers' compensation judge will at the time of hearing have the benefit of expert medical opinion from a third-party evaluator who is independent of both the treating and UR physicians. This helps assure that a final decision is justly made by a workers' compensation judge based upon substantial medical evidence." *Gregory Willis vs. Waste Management*; ADJ7803213, (Opinion and Order Dismissing Petition for Removal, Order Granting Reconsideration on Motion of the Appeals Board, and Opinion and Decision After Reconsideration, 10/14/2011)

Up to this point, it has been common for applicant's counsel to go to bat against a UR non-certification of a treatment request based solely on the report of the treating physician requesting the treatment authorization, but apparently that may not be sufficient if this decision becomes the rule of law. The cautionary note, of course, is that this is a panel decision and does not necessarily bind any judge at the trial level. And, as discussed below, the time it will take to resolve a treatment dispute may be significant.

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Tempest in a Timepot

It may be that California has taken yet another step in substituting form over substance by pinning down, almost to the last minute, the time the parties must wait and attempt to negotiate an Agreed Medical Examiner before requesting a panel QME. In *Tsegay Messele v. Pitco Foods, Inc.*, 76 Cal. Comp. Cases 956, (ADJ7232076), the WCAB issued an *en banc* decision that the time period set forth in Labor Code § 4062.2(b) for seeking an agreement on an AME (and during which you may not request a QME panel) starts with the first date of the first written proposal objecting to the report of a treating physician and proposing an AME, and includes the last day. It further noted the time period (10 days) is extended by CCP 1013(a) another 5 days in most instances, but in some cases (for parties outside California) for as much as another 15 Days. There is no hedge room in the procedure even when you really don't want to use an AME. Making the request early, even by one day, will disqualify it.

A recent inquiry to the DWC Medical Unit indicates that, for represented parties, the Unit is just now getting around to proper requests made more than 90 days ago, meaning that, from the time you decide you really want a panel QME, you will probably have to wait at least 100 days before you receive a panel list to review. After that, following the process, you will be looking at probably at least another eight weeks before the exam can take place. We used to shun Agreed Medical Examiners because of the lengthy delays involved but in many cases we are finding far less technical booby traps and even less delay

in getting to agreed doctors to resolve medical questions. It is something to consider in the appropriate case.

Ed note: We tried making the same inquiry of the medical unit as we completed this issue. After listening to an interminably long message and selecting an option to get info on the date of requests currently being processed, we were advised that our request was invalid. Why are we not surprised?

Almaraz/Guzman: Now What?

It's the law, the challenges having predictably failed in the appellate process. Therefore, a doctor is free to *attempt* to assert that the strict application of the *AMA Guides* is inadequate to correctly and accurately describe an injured worker's whole person impairment.

"But wait!" - as the guy in the commercial likes to say. Easier said than done. We have seen any number of attempts which fall short of what we believe the case law requires in order to support a deviation from strict AMA analysis. Even then, the doctor is not free to pluck any straw to support an argument that the rating should be super-sized. The reports must still present the strict analysis, and following that, must then present a cogent argument based on *medicine* and *facts* to demonstrate that the rating for the particular case should go above and beyond, including the "how and why" of the argument. Even then, the doctor may not go beyond the pages of the *Guides* to perform an alternative impairment analysis of what the correct impairment rating should be. For details on

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the requirements, see *Almaraz v. Environmental Recovery Services*, and *Guzman v. Milpitas Unified School District*, 74 Cal. Comp. Cases 1084 (WCAB *en banc*)

Ogilvie: Muddy Waters Keep on Rollin'

On July 29, 2011, the 1st DCA issued a decision in *Wanda Ogilvie v. Workers' Compensation Appeals Board; City and County of San Francisco v. Workers' Compensation Appeals Board* (Ogilvie), 197 Cal. App. 4th 1262, 76 Cal. Comp. Cases 624, rejecting a mathematical formula that the WCAB had created to rebut the diminished future earning capacity (DFEC) portion of the formula used to calculate permanent disability rebuttals. The 1st DCA's decision identified three rebuttal techniques that injured workers can use to show that a scheduled rating is inaccurate. The defendant is attempting to get the Supreme Court to take the case. Unfortunately (or perhaps fortunately) the guidelines for these approaches appear so vague and amorphous that we can't find anyone who can clearly state what they are. Although we now see far fewer Ogilvie type rating challenges, they are still being attempted by some applicant's counsel. We saw one such case headed for trial in Santa Ana recently and queried the judge as to what he felt was needed to make a substantial challenge under Ogilvie. The answer was reminiscent of the famous U.S. Supreme Court opinion in 1964 when Justice Potter Stewart tried to explain "hard-core" pornography, or what is obscene, by saying, "I shall not today attempt further to define the kinds of material I understand to be embraced . . . [b]ut I know it when I see it . . . " *Jacobellis v. Ohio*, 378 U.S. 184, 197 (1964)

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[Howard Stevens](#) (Orange office), Editor

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