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FIRM NEWS:

PASS-THROUGH LIEN RAISES ISSUES FOR TRIAL; LIEN DEFENSED

Attorneys Jonarde Raab, Richard Weyuker and Jennifer Sanden recently secured a take nothing defending the lien of Access Mediquip for spinal surgery hardware costs on behalf of AWCA/JPIA. The lien, which was $85,623, was denied by WCJ Pusey of the San Bernardino WCAB after a trial on February 3, 2015.

Applicant underwent implantation of a spinal column stimulator and related hardware at an outpatient surgery center due to his industrial injury. The procedure was performed on 3/23/10; the surgery center sent a bill which was promptly adjusted by the claims administrator. The bill did not include the cost of the implanted hardware.

Lien claimant bought the hardware from the manufacturer for $27,836 and sold it to the surgery center for an unknown amount. However, the surgery center did not bill defendant for the hardware in its facility fee and lien claimant alleged that because of this, it could bill defendant for the hardware directly.

Attorneys Raab, Weyuker and Sanden raised the following defenses to the lien:

1 – Rule 9789.32 provides that if certain procedures are performed in an outpatient surgery center, including the procedure performed in this case, the costs of implantable hardware are to be included in the facility fee;

2 – Lien claimant had litigated the identical issue in another case and had lost on the merits; thus it is precluded from re-litigating the same issue in a different case under the principle of collateral estoppel. Defendant had secured the briefs, trial decision and Order Denying Reconsideration in favor of a defendant in a case where lien claimant had lost an effort to recover the costs of surgical

NEWS, OPINIONS, AND LEGAL UPDATES

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THIS ISSUE:

hardware outside of the facility fee and requested that the Board take judicial notice of this previous decision;

3 – The lien was improper because lien claimant had no contractual relationship with applicant, and Labor Code section 4903 only allows liens for which applicant has a direct obligation; therefore, lien claimant lacks standing to proceed on its lien.

WCJ Pusey found that lien claimant was not entitled to collect anything on its lien, finding that Rule 9789.32 did not permit for billing in excess of the facility fee which defendant had already paid in full. As a second reason to bar the lien, the WCJ found that lien claimant was collaterally estopped from litigating the issue.

The issue of collateral estoppel bears some evaluation. Collateral estoppel bars a party from litigating an issue which it has unsuccessfully litigated in another case, even if the other party is different. The rules for the application of this doctrine were recently enunciated by the Supreme Court in *Pacific Lumber Co. v. State Water Resources Control Bd.* (2006) 37 Cal.4th 921, at 943:

"First, the issues sought to be precluded from re-litigation must be identical to that decided in a former proceeding. Second, this issue must have been fully litigated in the former proceeding. Third, it must have been necessarily decided in the former proceeding. Fourth, the decision in the former proceeding must be final and on the merits. Finally, the party against whom preclusion is sought must be the same as, or in privy with, the party to the former proceeding."

This is the so-called "defensive" use of collateral estoppel. If lien claimant had previously been successful prosecuting its lien in another case on a similar theory but the defendant was not the same, lien claimant could not assert its previous victory against a different defendant under collateral estoppel. This would be contrary to the last rule enunciated by the Supreme Court above: the party against whom the preclusion is sought must be the same.

In this case, since lien claimant had made an identical effort to recover the costs of implantable hardware outside of the facility fee allowed by Rule 9789.32 and lost, the trial decision and Order Denying Reconsideration in that previous case were asserted against lien claimant to preclude it from re-litigating the same issue.

APPLICATION:
1 – If a charge for hardware is supposed to be included in the facility fee, the provider cannot avoid this by not billing the facility and then seeking direct reimbursement from the employer/carrier;
2 – You have to prove that the procedure, hardware and facility meet the requirement for the inclusion of the charges for the hardware in the facility fee. This may require expert testimony at trial.
3 – If you receive a lien under these circumstances, ask your bill reviewer if it is aware of similar cases involving this lien claimant where the lien was defensed at trial. If so, you may be able to preclude lien claimant from re-litigating the same issue under collateral estoppel.

ASKING THE RIGHT QUESTIONS IN A LETTER TO A PSYCHIATRIC QME/AME

By Christopher M. Wagner

In *Fujimoto v. Caliber Collision Centers* (2014) 2014 Cal. Wrk. Comp. P.D. LEXIS 118, a WCAB panel denied an applicant's Petition for Reconsideration in a case where a workers' compensation judge

found that applicant did not sustain a compensable psychiatric injury.

Applicant, an auto body technician, filed a CT claim through 9/2/10 alleging injury to the psyche due to harassment by co-workers. The parties agreed to use Myron Nathan, M.D. as an AME. Dr. Nathan found that 90% of applicant's psyche injury was caused by work related stress. He issue a report and the parties proceeded to trial, but at the time of trial the WCJ ordered the parties to obtain a "definitive report" from the AME consistent with the *Rolda* framework.

(In *Rolda v. Pitney Bowes, Inc.* (2001) 66 Cal Comp Cases 241 the WCAB issued an en banc decision providing an analytical approach to addressing cases involving psychiatric claims.

Step 1: Does the alleged injury involve actual events of employment? (determined by trier of fact)
Step 2: Does the medical evidence establish that the actual events of employment were the predominant cause (at least 51%) of the injury?
Step 3: Were any of the actual events personnel actions? (determined by trier of fact)
Step 4: Were the personnel actions lawful, nondiscriminatory and made in good faith? (determined by trier of fact)
Step 5: Does the medical evidence establish that the lawful, nondiscriminatory, good faith personnel actions are a "substantial cause" (at least 35% to 40%) of the psyche injury?)

The AME then issued two supplemental reports. In the first, he stated that actual events of employment were the predominant cause and that these events were not personnel actions. In his next report he stated that he did not believe that applicant was "100% credible and reliable."

The case proceeded again to trial and applicant testified to various allegations of harassment (placement of dead rats on his toolbox, co-workers drilled a hole in the bathroom and used a camera to watch him use the bathroom and uploaded it onto the internet, sexually explicit graffiti on the bathroom wall, tampering with his toothbrush, installation of tape recorders in applicant's car, etc.). Defendant put forth various witnesses to rebut these allegations.

After the case was submitted at trial, the WCJ vacated his submission order and requested another supplemental report from the AME after concluding that the AME still had not adequately answered the *Rolda* questions. The WCJ wrote the following letter to the AME:

"[Please] provide a supplemental report that describes in detail, in accordance with *Rolda*, all the workplace and all the non-industrial related events and/or issues that combined caused the Applicant's psychological injury. You are then to assign a percentage of causation separately to each individual work-related and/or non-industrial event(s) and/or issue(s) that, when combined, equal 100% of the causation of the Applicant's psychological injury. You are not to combine percentages as to any multiple factors and/or issues, either industrial or non-industrial.

It will ultimately be up to me to decide which workplace activities are actual events (i.e., which of the event(s) described by the Applicant happened or not) and whether those events that I have deemed to be actual events are otherwise legitimate, non-discriminatory, good faith personnel actions. Based on this, I can determine if the actual events of employment, if added together, will result in them being the predominant cause (i.e., more than 50%) of the Applicant's psychological injury, and whether those actual causes were substantially caused (i.e., 35% to 40%) by lawful, nondiscriminatory, good faith personnel actions.

Your discussion should follow of the following format:
[Employment Event #1] – [Percentage of Causation]
[Employment Event #2] – [Percentage of Causation]
[Non-industrial Factors and/or Events #1] – [Percentage of Causation]
[Non-industrial Factors and/or Events #2] – [Percentage of Causation]
Total: 100%"

In response, the AME issued a report assigning a separate percentage of causation to 11 different events of employment (totaling 90% industrial causation). He only assigned 4% causation to the obscene graffiti on the bathroom wall. The WCJ found the defense witnesses to be credible whereas he found applicant to be "patently dishonest" and that the alleged work related stressors were "facetious and delusional." The WCJ determined that the obscene graffiti (4% causation) was the only actual event of employment that occurred. Thus, the predominant cause threshold was not met and the WCJ issued a take nothing.

Reconsideration was denied and the Panel emphasized that a WCJ's credibility determination is given great weight. They also noted that applicant offered no other evidence to corroborate the alleged actual events other than his testimony.

This case illustrates the roles of the WCJ and the AME in applying the *Rolda* analysis. It underscores the importance for the psyche medical-legal evaluator to identify each alleged actual event and separately assign each event its own percent of causation.

The letter from the WCJ to the AME contains good language you may want to include in your purpose letters. The case also highlights a WCJ's ability to develop the record when necessary.

If you have suggestions for an article, or feedback about anything that you read here, please be sure and let us know at our website, www.cbwmlaw.com .

Best Practices for Getting the Panel Specialty You Want in Represented Cases

By Kirsten N. Hale

Panel specialty disputes are frequently litigated and frequently result in the parties agreeing to an AME at a status conference. Often the AME is not the defendant's first choice, but a better alternative to a pain management or chiropractic panel QME.

Careful, timely attention to incoming medical reports or claim denials at the beginning of the case can reduce panel dispute litigation.

If the claim is denied, you should consider early whether your denial is likely to stand up on its own. If not, you may want or need a QME to address compensability. If the denial is based on a factual dispute, a statutory defense (i.e. horseplay, statute of limitations) or on a well-reasoned report from a treating doctor, you may not need a QME and may prefer to proceed on the current record.

If you do need a panel or anticipate that applicant's attorney will request one, you should send out a panel request for defendant's preferred specialty on the sixteenth day after the denial goes out. Applicant's attorney's offices rarely miss the opportunity to request a panel in an applicant-friendly specialty once there is a claim denial, so a defendant's sending out a request on the sixteenth day can be crucial.

If one or more body parts are accepted, each incoming primary treating physician report should be scrutinized for a basis for objection (objections to work restrictions or TD status are usually applicable). It is important to do this early in the case before the applicant has a

chance to switch to a treater in an applicant-friendly specialty. You should send an objection letter to applicant's attorney naming the date of the report, the author of the report, and the basis for objection. *The objection letter should be sent within 20 days of receipt of the primary treater's report.* You may request a panel on the sixteenth day after you send the objection letter — again, timeliness is important here in order to beat the applicant's attorney to the Medical Unit.

If the specialty requested differs from the primary treater's specialty, 8 CCR 31.1(b) requires that "documentation" be submitted as to the appropriateness of the requested specialty. This documentation could include a medical report recommending a consultation with an orthopedist, an RFA for psychiatric medication, an MRI showing a potentially surgical condition, etc. Failing such documentation, it is advisable to write a cover letter to the Medical Unit explaining the basis for the request of the particular specialty (e.g. "Applicant sustained a broken femur and therefore should be evaluated by an orthopedist"). Finally, the objection letter, the report being objected to, and any supporting documentation for requested specialty should be submitted with the panel request.

Note: The DWC is considering enacting regulations which would require the parties in represented cases to make QME panel requests on line. A hearing on new proposed regulations is scheduled to take place on May 22, 2015 at the State Building in Oakland. The amendment to Rule 30 is available online at the DIR website.

PRACTICE TIPS

ONE IN A SERIES OF ARTICLES TO HELP WITH DAY TO DAY ISSUES FACING ADJUSTERS AND EMPLOYERS

GETTING YOUR SETTLEMENTS APPROVED BY THE WCAB

If you want to secure approval of a settlement, especially in an unlitigated case, here are a few suggestions that may keep you out of trouble:

1 – **Use the Uniform Assigned Names** (UAN) and addresses designated in EAMS for the employer, carrier and administrator where applicable.
2 – In Stipulations, be sure to **include interest waiver language**. (It is unnecessary in a Compromise and Release – it is part of the form.)
3 – **Include the rating string** in Paragraph 9 of the Stipulations or C&R – file any DEU or private rating that supports your rating string with the settlement documents.
4 - In addition to filing any rating, you should **file**

- **Medical reports** that the settlement is based on
- **Wage statement** if less than maximum rates have been paid
- **Notice** of right to QME if no QME report has been obtained
- If this is a pre-1/1/13 injury, supporting documents regarding a timely **return-to-work** offer per Labor Code section 4658 (d) (or the absence of the same) and the settlement documents should reflect these

- **Benefit printout**
- If credits are claimed for **overpayments**, all notices that explains the overpayments

5 – When you file the settlement documents and any other documents that assist the Board in determining adequacy, file them with a **"file and serve" letter** showing all documents which are being filed. Show a copy of this letter being sent to applicant

6 – File settlement documents with **proof of service** showing service on all lien claimants of record (as well as applicant) – do not send any medicals to a lien claimant (other than a doctor) without WCAB approval

7 – **Supplemental Job Displacement Benefits** (voucher) cannot be settled for injuries on or after 1/1/13 (unless perhaps injury AOE-COE is at issue). Some District Offices of the Board will require a specific finding regarding entitlement to the voucher in the settlement documents

8 – File **proposed Award or Order Approving C&R** with settlement documents

9 – Make sure that the **figures** in the C&R or Stipulations match the Order Approving/Award and match the benefit printout

10 – Avoid form **addenda**. The Board disfavors them. If there is a reason to explain the settlement that doesn't fit in Paragraph 9 of the C&R, an addendum is helpful, but don't use form addenda

11 – If there are unresolved **liens**, include language in Paragraph 8 of Stipulations or C&R explaining what efforts have been made to resolve them. Don't simply indicate that defendant will pay/adjust/litigate or hold applicant harmless

12 – Are the **body parts** listed properly in the settlement documents? In a C&R, list as many as the medical record will allow; for Stipulations, draw them as narrowly as the medical record will allow

13 – The settlement should be properly **signed** and witnessed or notarized

14 – The **employer and carrier** (if applicable) should be properly identified in the settlement documents. The Award/Order Approving should be **payable** by the correct paying entity