LATINO COMP

A LATINO/A ASSOCIATION OF WORKERS' COMPENSATION PROFESSIONALS

Bi-Monthly Educational Meeting
March 21, 2019
Luminarias Restaurant

PD AND THE VALUE OF FUTURE MEDICAL

DENTISTRY ISSUES IN WORKERS COMPENSATION
WINTER CONVENTION RECAP
MEDICARE SET-ASIDE ALLOCATION
MAXIMIZE YOUR SETTLEMENT

Speakers

Vivek Solanki, DDS, QME
Periodontics & Implant Dentistry

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Latino Comp Seminar
March 21, 2019

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1

Who we are?

- Team of Dentists, Board certified Specialists, and QME's
- Handle all dental cases regardless of size/injury
- Comprehensive dental care/reconstruction and TMJ therapy
- Multiple Locations for evaluation and treatment
  - Oceanside (North SD), Torrance, Brentwood (LA), Ventura, Sherman Oaks, Corona, Ontario

2

Questions: Does this apply to you?

- *Are you having trouble with treating physicians addressing all body parts claimed by the applicants?*
- *Are you having problems communicating with Doctors regarding reports, treatment & follow up?*
- *How many of your clients are getting their pain medications denied by UR?*
- *How many old cases do you have where clients have taken chronic medications?*

3

Types of Dental injuries

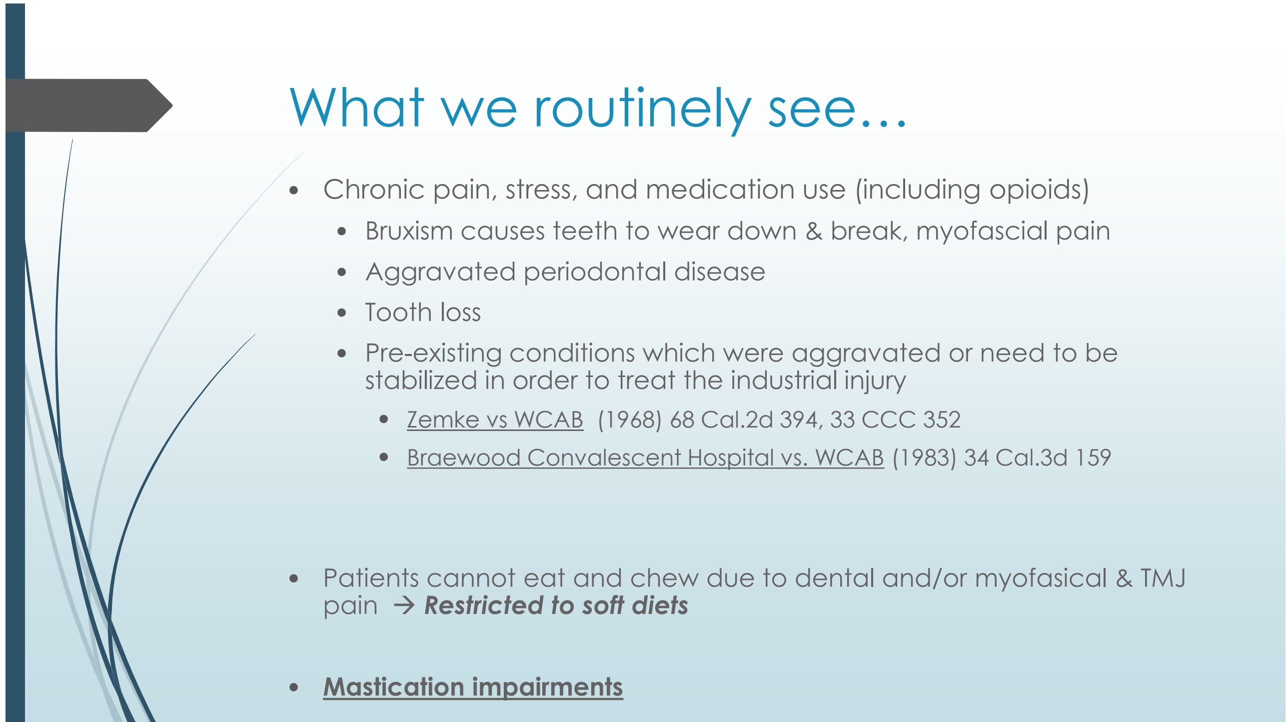
- ***Direct injuries***
  - Less common and usually not disputed
- ***Compensable consequence injuries***
  - More Common, often overlooked
  - Dental is often an ignored aspect in workers comp
  - Secondary complication from bodily injury
  - Chronic pain, psych- stress & depression
  - Chronic medication usage
  - ”Disputed body part” → referral & report → QME/AME

4

Derived injuries

- ***Bruxism – Grinding and clenching***
- ***Xerostomia – Dry mouth often from multiple medications***
- ***Temporomandibular joint pain TMD/TMJ***
- ***Dental decay & aggravated periodontal disease***
- ***Myofascial pain & headaches***

5



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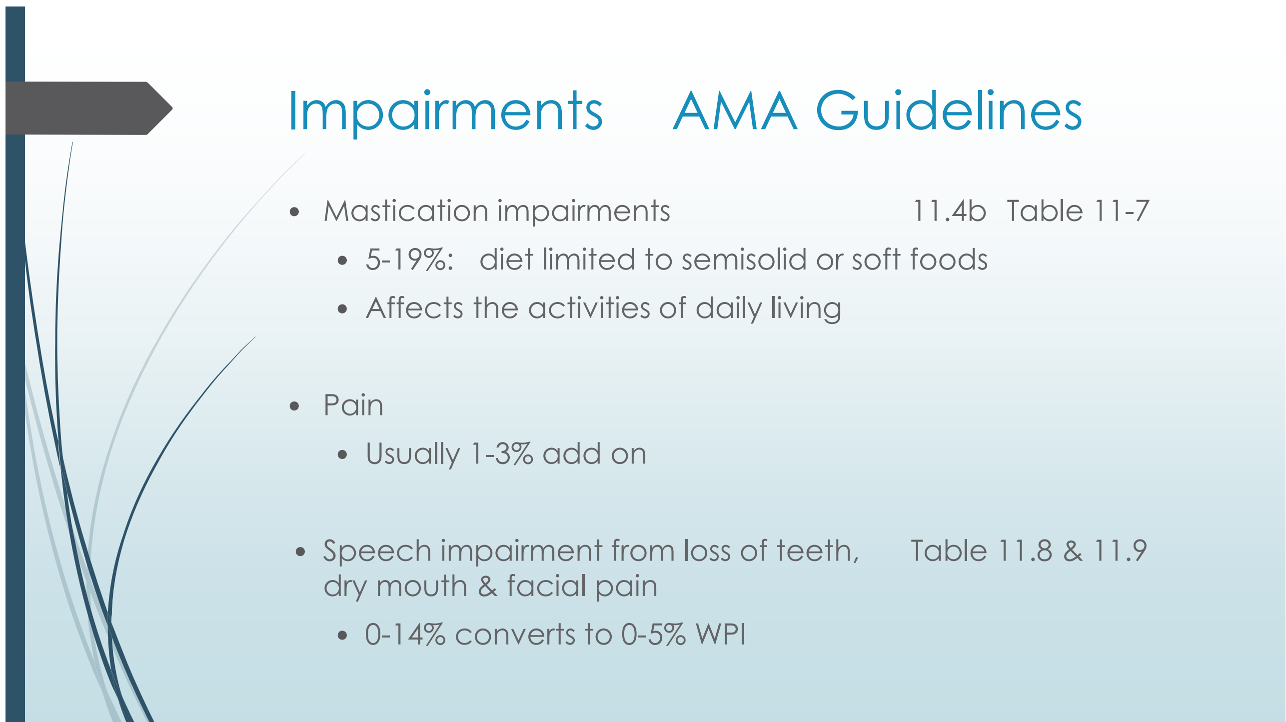

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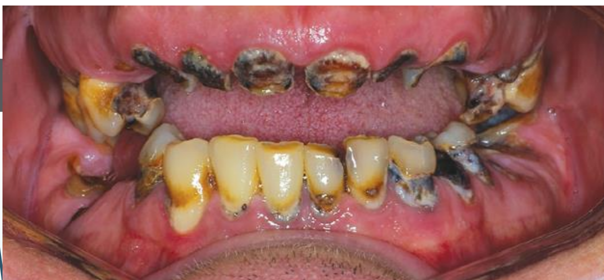
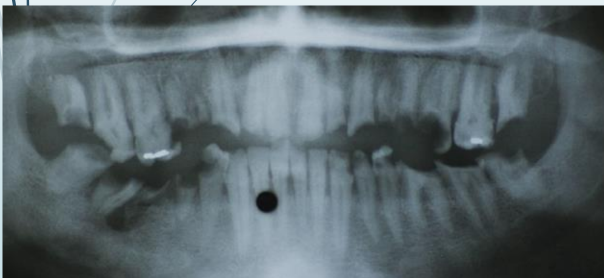
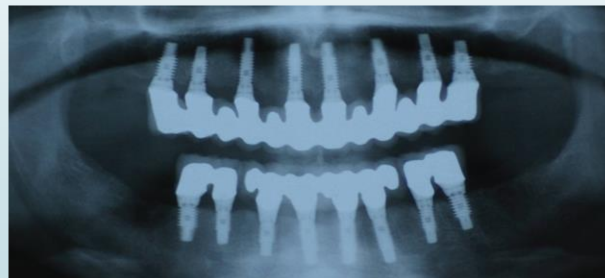
How can we help?

- *Once evaluated, in addition to addressing other body parts there may be **dental impairments** which will be **estimated** in the report*
- *In severe cases, during dental reconstruction, I will comment on the need for work restrictions. This may entitle your clients to temporary disability payments.*
- *Denied and & Disputed cases welcome. A comprehensive medical legal evaluation will be provided.*
    - *(Please ask about the referral process)*

8



Severe Case: Full mouth reconstruction: Bruxism, Xerostomia, Decay & Pain

9

How can we help

- Every report is unique and tailored specifically for your client; photos, x-rays included. *No boiler plate reports*
- Dental reconstruction time can range from 8-16 months.
- Communication is key, it is also a two way street.
- Dental screener questionnaire and medication list will be provided

10

Thank you for your attention!

11

Vivek Solanki, DDS, QME
PROVIDING COMPREHENSIVE TMJ AND DENTAL CARE
Board Certified in Periodontics & Implant Dentistry
Qualified Medical Evaluator

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Dental and TMJ screening questionnaire

1.	Have your teeth or the condition of your oral health changed since your industrial injury?	Yes	No
2.	Do you have dry mouth, or any difficulty chewing or swallowing?	Yes	No
3.	Are you clenching and grinding your teeth?	Yes	No
4.	Does your jaw or facial musculature hurt?	Yes	No
5.	Do you have bleeding gums?	Yes	No
6.	Are your teeth loose or breaking into smaller pieces?	Yes	No
7.	Was your last dental evaluation before your industrial injury?	Yes	No

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Medications that cause **Bruxism**

- Citalopram (Celexa, Cipramil)
- Escitalopram (Lexapro, Cipralex)
- Paroxetine (Paxil, Seroxat)
- Fluoxetine (Prozac)
- Fluvoxamine (Luvox, Faverin)
- Sertraline (Zoloft, Lustral)

Medications that cause **Gum overgrowth**

- Anticonvulsants: phenytoin, phenobarbital, lamotrigine, vigabatrin, ethosuximide, topiramate and primidone
- calcium channel blockers: nifedipine, amlodipine, and verapamil
- cyclosporine: an immunosuppressant

Attached is a list of medications that causes **Xerostomia (dry mouth)**

Common Prescriptions Associated with Xerostomia

Of the top 20 most prescribed drugs in the U.S.A. in 2010, the following 15 are associated with xerostomia

1. Hydrocodone and Acetaminaphen, narcotic
2. Lisinopril (Prinivil/Zestril), antihypertensive
3. Simvastin (Zocor), antiperlipidemic
4. Amlodipine (Norvasc), antihypertensive
5. Alprazolam (Xanax), anti-anxiety
6. Hydrochlorothiazide, diuretic
7. Omeprazole (Prilosec), anti-ulcer agent
8. Lipitor, antihyperlipidemic
9. Furosemide (Lasix), diuretic
10. Metoprolol (Lopressor), antihypertensive
11. Sertaline (Zoloft), antidepressant
12. Metoprolol (Toprol), antihypertensive
13. Zolpidem (Ambien), seadtive/hypnotic
14. Oxycodone and Acetaminophen, narcotic
15. Citalopram (Celexa), antidepressant

CR information assembled from a variety of data to reflect the prevalence of xerostomia among top prescription medications.
Top resources include: Dental Lexi-Drugs (Lexicomp) and www.drymouth.info/practitioner/treatment.asp.

348 Medications and Drugs that Cause Xerostomia

Drugs are listed in alphabetical order by generic name. Source: The American Dental Association / Physician's Desk Reference Guide to Dental Therapeutics

1. Abciximab—Marketed under the brand name Reopro
2. Acamprosate Calcium—Marketed under the brand name Campral
3. Acetaminophen with Tramadol—Marketed under the brand name Ultracet
4. Acetaminophen with Butalbital with Caffeine with Codeine Phosphate—Marketed under the brand name Phrenilin
5. Adenosine—Marketed under the brand name Adenoscan
6. Albuterol Sulfate with Ipratropium Bromide—Marketed under the brand name Combivent
7. Albuterol Sulfate—Marketed under the brand names Proventil and Ventolin
8. Almotriptan Malate—Marketed under the brand name Axert
9. Alprazolam—Marketed under the brand names Niravam and Xanax
10. Alprostadil—Marketed under the brand name Caverject
11. Amantadine Hydrochloride—Marketed under the brand name Symmetrel
12. Amiloride Hydrochloride—Marketed under the brand name Midamor
13. Amiloride Hydrochloride with Hydrochlorothiazide—Marketed under the brand name Moduretic
14. Amitriptyline Hydrochloride Amlodipine Besylate with Atorvastatin—Marketed under the brand name Caduet
15. Amlodipine Besylate with Benazepril Hydrochloride—Marketed under the brand name Lotrel
16. Amlodipine Besylate—Marketed under the brand name Norvasc
17. Amoxicillin with Clarithromycin with Lansoprazole—Marketed under the brand name PREVPAC
18. Amphetamine Aspartate with Amphetamine Sulfate with Dextroamphetamine Saccharate with Dextroamphetamine Sulfate—Marketed under the brand name Adderall
19. Amphotericin B. Liposomal—Marketed under the brand name Ambisome
20. Anastrozole—Marketed under the brand name Arimidex
21. Aripiprazole—Marketed under the brand name Abilify
22. Arsenic Trioxide—Marketed under the brand name Trisenox
23. Aspirin with Caffeine with Orphenadrine Citrate—Marketed under the brand name Norgesic
24. Atenolol with Chlorthalidone—Marketed under the brand name Tenoretic
25. Atenolol—Marketed under the brand name Tenormin
26. Atomoxetine Hydrochloride—Marketed under the brand name Strattera
27. Atorvastatin Calcium—Marketed under the brand name Lipitor
28. Atropine Sulfate—Marketed under the brand name Motofen
29. Atropine Sulfate with Benzoic Acid with Hyoscyamine with Methenamine with Methylene Blue with Phenyl Salicylate—Marketed under the brand name Urised
30. Atropine Sulfate with Hyoscyamine Sulfate with Phenobarbital with Scopolamine Hydrobromide—Marketed under the brand name Donnatal
31. Azatadine Maleate—Marketed under the brand name Trinalin
32. Azelastine Hydrochloride—Marketed under the brand name Astelin
33. Balsalazide Disodium—Marketed under the brand name Colazal
34. Beclomethasone Dipropionate—Marketed under the brand names Beclovent and Vanceril
35. Belladonna Alkaloids with Phenobarbital—Marketed under the brand name Donnatal
36. Belladonna Alkaloids with Hyoscyamine Sulfate with Methenamine with Methylene Blue with Phenyl Salicylate with Sodium Biphosphate—Marketed under the brand name Urimax
37. Benazepril Hydrochloride—Marketed under the brand name Lotensin
38. Bendroflumethiazide—Marketed under the brand name Corzide
39. Benztropine Mesylate—Marketed under the brand name Cogentin
40. Bepridil Hydrochloride—Marketed under the brand name Vascor
41. Betaxolol Hydrochloride—Marketed under the brand name Kerlone
42. Bevacizumab—Marketed under the brand name Avastin
43. Bexarotene—Marketed under the brand name Targretin
44. Bicalutamide—Marketed under the brand name Casodex
45. Biperiden Hydrochloride—Marketed under the brand name Akineton
46. Brimonidine Tartrate—Marketed under the brand name Alphagan
47. Brinzolamide—Marketed under the brand name Azopt
48. Brompheniramine Maleate—Marketed under the brand names Bromfed and Dimetane
49. Brompheniramine with Phenylpropanolamine with Codeine—Marketed under the brand name Dimetane-DX
50. Budesonide—Marketed under the brand names Pulmicort and Rhinocort
51. Bupropion Hydrochloride—Marketed under the brand names Wellbutrin and Zyban
52. Buspirone Hydrochloride—Marketed under the brand name Buspar
53. Butabarbital with Fluoxetine Hydrochloride with Hyoscyamine Hydrobromide with Phenazopyridine Hydrochloride—Marketed under the brand name Pyridium
54. Cabergoline—Marketed under the brand name Dostinex
55. Calcitonin-Salmon—Marketed under the brand names Fortical and Miacalcin
56. Calcitriol—Marketed under the brand name Calcijex
57. Capecitabine—Marketed under the brand name Xeloda
58. Captopril—Marketed under the brand name Captopril
59. Carbamazepine—Marketed under the brand names Carbatrol, Equetro, and Tegretol
60. Carbidopa—Marketed under the brand name Lodosyn
61. Carbidopa with Levodopa—Marketed under the brand names Parcopa and Sinemet
62. Carbidopa with Entacapone with Levodopa—Marketed under the brand name Stalevo
63. Carbinoxamine Maleate with Dextromethorphan Hydrobromide with Pseudoephedrine Hydrochloride—Marketed under the brand name Balamine
64. Carvedilol—Marketed under the brand name Coreg
65. Cefdinir—Marketed under the brand name Omnicef
66. Cefditoren Pivoxil—Marketed under the brand name Spectracef
67. Cefpodoxime Proxetil—Marketed under the brand name Vantin
68. Celecoxib—Marketed under the brand name Celebrex
69. Cetirizine Hydrochloride—Marketed under the brand name Zyrtec

70. Cetirizine Hydrochloride with Pseudoephedrine—Marketed under the brand name Zyrtec-D
71. Cevimeline Hydrochloride—Marketed under the brand name Evoxac
72. Chlorothiazide Sodium—Marketed under the brand name Diuril
73. Chlorpheniramine Maleate—Marketed under the brand name Chlor-Trimeton
74. Chlorpromazine—Marketed under the brand name Thorazine
75. Chlorthalidone—Marketed under the brand names Thalitone and Hygroton
76. Ciprofloxacin—Marketed under the brand name Cipro
77. Cisapride—Marketed under the brand name Propulsid
78. Citalopram Hydrobromide—Marketed under the brand name Celexa
79. Clonazepam—Marketed under the brand name Klonopin
80. Clonidine—Marketed under the brand names Catapres and Catapres-TTS
81. Clonidine with Chlorthalidone—Marketed under the brand name Combipres
82. Clorazepate Dipotassium—Marketed under the brand name Tranxene-SD
83. Clozapine—Marketed under the brand names Clozaril and Faxaclo
84. Codeine
85. Cyclobenzaprine Hydrochloride—Marketed under the brand name Flexeril
86. Cyclosporine—Marketed under the brand names Gengraf and Neoral
87. Darifenacin—Marketed under the brand name Enablex
88. Delavirdine Mesylate—Marketed under the brand name Rescriptor
89. Desipramine—Marketed under the brand name Norpramin
90. Desloratadine—Marketed under the brand name Clarinex
91. Desloratadine with Loratadine with Pseudoephedrine Sulfate—Marketed under the brand name Clarinex-D
92. Dexmethylphenidate Hydrochloride—Marketed under the brand name Focalin
93. Dextroamphetamine Sulfate—Marketed under the brand names Dexedrine and Dextrostat
94. Diazepam—Marketed under the brand name Valium
95. Diazoxide—Marketed under the brand name Hyperstat
96. Diclofenac Potassium—Marketed under the brand name Cataflam
97. Diclofenac Sodium with Misoprostol—Marketed under the brand name Arthrotec
98. Diclofenac Sodium—Marketed under the brand names Voltaren and Voltaren-XR
99. Dicyclomine Hydrochloride—Marketed under the brand name Bentyl
100. Diethylpropion Hydrochloride USP—Marketed under the brand name Tenuate
101. Diflunisal—Marketed under the brand name Dolobid
102. Dihydroergotamine Mesylate—Marketed under the brand name Migranal
103. Diltiazem Hydrochloride—Marketed under the brand names Cardizem, Dilacor, and Tiazac
104. Diphenhydramine—Marketed under the brand names Dramamine and Benadryl
105. Disopyramide Phosphate—Marketed under the brand name Norpace
106. Divalproex Sodium—Marketed under the brand name Depakote
107. Donepezil Hydrochloride—Marketed under the brand name Aricept
108. Dorzolamide Hydrochloride—Marketed under the brand names Cosopt and Trusopt
109. Doxepin Hydrochloride—Marketed under the brand name Prudoxin
110. Doxercalciferol—Marketed under the brand name Hectorol
111. Doxorubicin Hydrochloride Liposome—Marketed under the brand name Doxil
112. Duloxetine Hydrochloride—Marketed under the brand name Cymbalta
113. Eletriptan Hydrobromide—Marketed under the brand name Relpax
114. Enalapril Maleate with Hydrochlorothiazide—Marketed under the brand name Vaseretic
115. Enalapril Maleate—Marketed under the brand name Vasotec
116. Enalaprilat
117. Enfuvirtide—Marketed under the brand name Fuzeon
118. Enoxacin—Marketed under the brand name Penetrex
119. Entacapone—Marketed under the brand name Comtan
120. Ephedrine Sulfate with Hydroxyzine Hydrochloride with Theophylline—Marketed under the brand name Marax
121. Eprosartan Mesylate—Marketed under the brand name Teveten
122. Escitalopram Oxalate—Marketed under the brand name Lexapro
123. Esmolol Hydrochloride—Marketed under the brand name Brevibloc
124. Esomeprazole Magnesium—Marketed under the brand name Nexium
125. Estazolam—Marketed under the brand name Prosom
126. Eszopiclone—Marketed under the brand name Lunesta
127. Etanercept—Marketed under the brand name Enbrel
128. Famotidine—Marketed under the brand name Pepcid
129. Felodipine—Marketed under the brand name Plendil
130. Fenofibrate—Marketed under the brand names Antara, Lofibra, and Tricor
131. Fenoprofen Calcium—Marketed under the brand name Nalfon
132. Fentanyl—Marketed under the brand name Duragesic
133. Fentanyl Citrate—Marketed under the brand name Actiq
134. Fexofenadine Hydrochloride—Marketed under the brand name Allegra-D
135. Flecainide Acetate—Marketed under the brand name Tambocor
136. Fluocinolone Acetonide with Hydroquinone with Tretinoin—Marketed under the brand name Tri-Luma
137. Fluoxetine Hydrochloride—Marketed under the brand name Prozac
138. Fluoxetine Hydrochloride with Olanzapine—Marketed under the brand name Symbyax
139. Flurazepam Hydrochloride—Marketed under the brand name Dalmane
140. Fluticasone Propionate with Salmeterol Xinafoate—Marketed under the brand name Advair
141. Fluvoxamine Maleate—Marketed under the brand name Luvox
142. Formoterol Fumarate—Marketed under the brand name Foradil
143. Foscarnet Sodium—Marketed under the brand name Foscavir
144. Fosinopril Sodium—Marketed under the brand name Monopril
145. Frovatriptan Succinate—Marketed under the brand name Frova
146. Furosemide—Marketed under the brand name Lasix
147. Gabapentin—Marketed under the brand name Neurontin
148. Galantamine Hydrobromide—Marketed under the brand name Razadyne
149. Ganciclovir—Marketed under the brand name Cytovene
150. Gemifloxacin Mesylate—Marketed under the brand name Factive
151. Glatiramer Acetate—Marketed under the brand name Copaxone
152. Glycopyrrolate—Marketed under the brand name Robinul
153. Goserelin Acetate—Marketed under the brand name Zoladex
154. Grepafloxacin Hydrochloride—Marketed under the brand name Raxar
155. Guanadrel Sulfate—Marketed under the brand name Hylorel
156. Guanfacine Hydrochloride—Marketed under the brand name Tenex
157. Guanidine Hydrochloride—Marketed under the brand name Guanidine
158. Haloperidol—Marketed under the brand name Haldol
159. Hydrochlorothiazide
160. Hydrochlorothiazide with Triamterene—Marketed under the brand name Dyazide
161. Hydrocodone Bitartrate with Ibuprofen—Marketed under the brand name Vicoprofen
162. Hydromorphone Hydrochloride—Marketed under the brand names Dilaudid and Dilaudid-HP
163. Hyoscyamine—Marketed under the brand names Cystospaz, Levbid, and Nulev
164. Ibuprofen—Marketed under the brand names Advil and Motrin
165. Ibuprofen with Oxycodone Hydrochloride—Marketed under the brand name Combunox
166. Imipramine Pamoate—Marketed under the brand name Tofranil
167. Interferon Alfa-2b, Recombinant—Marketed under the brand name Intron
168. Interferon Alfacon-1—Marketed under the brand name Infergen
169. Interferon Alfa-N3—Marketed under the brand name Human Leukocyte Derived.—Marketed under the brand name Alferon
170. Interferon Beta-1a—Marketed under the brand name Rebif
171. Ipratropium Bromide—Marketed under the brand name Atrovent
172. Isosorbide Mononitrate—Marketed under the brand names Imdur and Monoket
173. Isotretinoin—Marketed under the brand names Accutane and Amnesteem
174. Isradipine—Marketed under the brand name Dynacirc
175. Ketoprofen—Marketed under the brand name Orudis
176. Ketotifen Fumarate—Marketed under the brand name Zaditor
177. Lamotrigine—Marketed under the brand name Lamictal
178. Lansoprazole—Marketed under the brand name Prevacid
179. Leflunomide—Marketed under the brand name Arava
180. Leuprolide Acetate—Marketed under the brand names Lupron and Viadur
181. Levalbuterol Hydrochloride—Marketed under the brand name Xopenex
182. Levofloxacin—Marketed under the brand name Levaquin
183. Levomethadyl Acetate Hydrochloride—Marketed under the brand name Orlaam

184. Levorphanol Tartrate—Marketed under the brand name Levorphanol
185. Lisinopril—Marketed under the brand names Prinivil and Zestril
186. Lisinopril with Hydrochlorothiazide—Marketed under the brand name Zestoretic
187. Lithium Carbonate—Marketed under the brand names Eskalith and Lithobid
188. Lomefloxacin Hydrochloride—Marketed under the brand name Maxaquin
189. Loperamide Hydrochloride—Marketed under the brand name Imodium
190. Lopinavir with Ritonavir—Marketed under the brand name Kaletra
191. Loratadine—Marketed under the brand name Claritin
192. Loratadine with Pseudoephedrine—Marketed under the brand name Claritin-D
193. Losartan Potassium—Marketed under the brand name Cozaar
194. Losartan Potassium with Hydrochlorothiazide—Marketed under the brand name Hyzaar
195. Lovastatin with Niacin—Marketed under the brand name Advicor
196. Lovastatin—Marketed under the brand names Altoprev and Mevacor
197. Loxapine Hydrochloride—Marketed under the brand name Loxitane
198. Mecamylamine Hydrochloride—Marketed under the brand name Inversine
199. Meclizine Hydrochloride—Marketed under the brand names Antivert and Bonine
200. Mefenamic Acid—Marketed under the brand name Ponstel
201. Megestrol Acetate—Marketed under the brand name Megace
202. Meloxicam—Marketed under the brand name Mobic
203. Meperidine Hydrochloride—Marketed under the brand name Mepergan
204. Mesalamine—Marketed under the brand name Asacol
205. Metaproterenol Sulfate—Marketed under the brand name Alupent
206. Methadone Hydrochloride—Marketed under the brand names Dolophine and Methadone
207. Methamphetamine Hydrochloride—Marketed under the brand name Desoxyn
208. Methyldopate Hydrochloride—Marketed under the brand name Aldomet
209. Metoprolol Succinate—Marketed under the brand name Toprol-XL
210. Metronidazole—Marketed under the brand names Metrogel-Vaginal and Noritate
211. Metyrosine—Marketed under the brand name Demser
212. Midodrine Hydrochloride—Marketed under the brand name Proamatine
213. Mirtazapine—Marketed under the brand name Remeron
214. Modafinil—Marketed under the brand name Provigil
215. Moexipril Hydrochloride—Marketed under the brand name Univasc
216. Molindone Hydrochloride—Marketed under the brand name Moban
217. Mometasone Furoate—Marketed under the brand name Elocon
218. Moricizine Hydrochloride—Marketed under the brand name Ethmozine
219. Morphine Sulfate—Marketed under the brand names Avinza, Kadian, MSIR, and Roxanol
220. Moxifloxacin Hydrochloride—Marketed under the brand name Avelox
221. Mupirocin calcium—Marketed under the brand name Bactroban
222. Mycophenolate Mofetil—Marketed under the brand name Cellcept
223. Nabumetone—Marketed under the brand name Relafen
224. Nadolol—Marketed under the brand name Nadolol
225. Nalbuphine Hydrochloride—Marketed under the brand name Nubain
226. Naltrexone Hydrochloride—Marketed under the brand name Revia
227. Naproxen—Marketed under the brand names Aleve and Naprosyn
228. Nedocromil Sodium—Marketed under the brand name Tilade
229. Niacin—Marketed under the brand name Niaspan
230. Nicotine—Marketed under the brand names Habitrol, Nicorette, and Nicotrol
231. Nifedipine—Marketed under the brand name Adalat
232. Nisoldipine—Marketed under the brand name Sular
233. Nizatidine—Marketed under the brand name Axid
234. Norfloxacin—Marketed under the brand name Noroxin
235. Octreotide Acetate—Marketed under the brand name Sandostatin
236. Ofloxacin—Marketed under the brand name Floxin
237. Olanzapine—Marketed under the brand name Zyprexa
238. Omega-3-Acid Ethyl Esters—Marketed under the brand name Omacor
239. Omeprazole—Marketed under the brand names Prilosec and Zegerid
240. Ondansetron—Marketed under the brand name Zofran
241. Orphenadrine Citrate—Marketed under the brand name Norflex
242. Oxaliplatin—Marketed under the brand name Eloxatin
243. Oxcarbazepine—Marketed under the brand name Trileptal
244. Oxybutynin—Marketed under the brand name Oxytrol
245. Oxybutynin Chloride—Marketed under the brand name Ditropan
246. Oxycodone Hydrochloride—Marketed under the brand name Oxycontin
247. Oxymorphone Hydrochloride—Marketed under the brand name Numorphan
248. Palonosetron Hydrochloride—Marketed under the brand name Aloxi
249. Pantoprazole Sodium—Marketed under the brand name Protonix
250. Paricalcitol—Marketed under the brand name Zemplar
251. Paroxetine Hydrochloride—Marketed under the brand name Paxil
252. Peginterferon Alfa-2a—Marketed under the brand name Pegasys
253. Peginterferon Alfa-2b—Marketed under the brand name PEG-Intron
254. Pemetrexed—Marketed under the brand name Alimta
255. Pentazocine Hydrochloride—Marketed under the brand names Talwin and Talwin Nx
256. Pergolide Mesylate—Marketed under the brand name Permax
257. Perindopril Erbumine—Marketed under the brand name Aceon
258. Perphenazine—Marketed under the brand name Trilafon
259. Phenelzine sulfate—Marketed under the brand name Nardil
260. Phendimetrazine Tartrate—Marketed under the brand name Bontril
261. Phentermine Hydrochloride—Marketed under the brand names Adipex-P and Fastin
262. Pimozide—Marketed under the brand name Orap
263. Pirbuterol Acetate—Marketed under the brand name Maxair
264. Piroxicam—Marketed under the brand name Feldene
265. Pramipexole Dihydrochloride—Marketed under the brand name Mirapex
266. Pregabalin—Marketed under the brand name Lyrica
267. Procarbazine Hydrochloride—Marketed under the brand name Matulane
268. Prochlorperazine—Marketed under the brand names Compazine and Compro
269. Progesterone—Marketed under the brand names Crinone, Prochieve, and Prometrium
270. Promethazine Hydrochloride—Marketed under the brand name Phenergan
271. Propafenone Hydrochloride—Marketed under the brand name Rythmol
272. Propofol—Marketed under the brand names Diprivan and Propofol
273. Propoxyphene Hydrochloride—Marketed under the brand name Darvon
274. Protirelin—Marketed under the brand name Thyrel
275. Protriptyline Hydrochloride—Marketed under the brand name Vivactil
276. Quetiapine Fumarate—Marketed under the brand name Seroquel
277. Rabeprazole Sodium—Marketed under the brand name Aciphex
278. Ramipril—Marketed under the brand name Altace
279. Rescinnamine—Marketed under the brand name Moderil
280. Ribavirin—Marketed under the brand names Copegus and Rebetol
281. Riluzole—Marketed under the brand name Rilutek
282. Rimantadine Hydrochloride—Marketed under the brand name Flumadine
283. Risedronate Sodium—Marketed under the brand name Actonel
284. Risperidone—Marketed under the brand name Risperdal
285. Ritonavir—Marketed under the brand name Norvir
286. Rivastigmine Tartrate—Marketed under the brand name Exelon
287. Rizatriptan Benzoate—Marketed under the brand name Maxalt-MLT
288. Ropinirole Hydrochloride—Marketed under the brand name Requip
289. Salmeterol Xinafoate—Marketed under the brand name Serevent
290. Saquinavir Mesylate—Marketed under the brand name Invirase
291. Scopolamine—Marketed under the brand name Transderm
292. Selegiline Hydrochloride—Marketed under the brand name Eldepryl
293. Sertraline Hydrochloride—Marketed under the brand name Zoloft
294. Sevoflurane—Marketed under the brand name Ultane
295. Sibutramine Hydrochloride Monohydrate—Marketed under the brand name Meridia
296. Sildenafil Citrate—Marketed under the brand name Viagra
297. Sodium Ferric Gluconate—Marketed under the brand name Ferrlecit
298. Solifenacin Succinate—Marketed under the brand name Vesicare
299. Sparfloxacin—Marketed under the brand name Zagam
300. Sucralfate—Marketed under the brand name Carafate
301. Sulindac—Marketed under the brand name Clinoril
302. Sumatriptan Succinate—Marketed under the brand name Imitrex
303. Tadalafil—Marketed under the brand name Cialis
304. Telithromycin—Marketed under the brand name Ketek

348 Medications and Drugs That Cause Dry Mouth / Xerostomia *(Continued)*

305. Telmisartan—Marketed under the brand name Micardis
306. Temazepam—Marketed under the brand name Restoril
307. Terazosin Hydrochloride—Marketed under the brand name Hytrin
308. Terbutaline Sulfate—Marketed under the brand name Brethine
309. Testosterone—Marketed under the brand names Androgel, Testoderm, Striant, and Androderm
310. Thalidomide—Marketed under the brand name Thalomid
311. Thiabendazole—Marketed under the brand name Mintezol
312. Thioridazine Hydrochloride—Marketed under the brand name Thioridazine
313. Thiothixene—Marketed under the brand name Thiothixene
314. Tiagabine Hydrochloride—Marketed under the brand name Gabitril
315. Tigecycline—Marketed under the brand name Tygacil
316. Timolol Hemihydrate—Marketed under the brand name Betimol
317. Timolol Maleate—Marketed under the brand names Timoptic and Timoptic-XE
318. Tinidazole—Marketed under the brand name Tindamax
319. Tiotropium Bromide—Marketed under the brand name Spiriva
320. Tizanidine Hydrochloride—Marketed under the brand name Zanaflex
321. Tocainide Hydrochloride—Marketed under the brand name Tonocard
322. Tolcapone—Marketed under the brand name Tasmar
323. Tolterodine Tartrate—Marketed under the brand name Detrol
324. Topiramate—Marketed under the brand name Topamax
325. Tramadol Hydrochloride—Marketed under the brand name Ultram
326. Trandolapril with Verapamil Hydrochloride—Marketed under the brand name Tarka
327. Tranylcypromine Sulfate—Marketed under the brand name Parnate
328. Triamcinolone Acetonide—Marketed under the brand names Azmacort and Nasacort
329. Triamterene—Marketed under the brand name Dyrenium
330. Triamterene with Hydrochlorothiazide—Marketed under the brand names Maxzide and Dyazide
331. Triazolam—Marketed under the brand name Halcion
332. Trifluoperazine Hydrochloride—Marketed under the brand name Stelazine
333. Trihexyphenidyl Hydrochloride—Marketed under the brand name Artane
334. Trimipramine Maleate—Marketed under the brand name Surmontil
335. Trospium Chloride—Marketed under the brand name Sanctura
336. Valproate Sodium—Marketed under the brand name Depacon
337. Valproic Acid—Marketed under the brand name Depakene
338. Valsartan—Marketed under the brand name Diovan
339. Valsartin with Hydrochlorothiazide—Marketed under the brand name Diovan HCT
340. Vardenafil Hydrochloride—Marketed under the brand name Levitra
341. Venlafaxine Hydrochloride—Marketed under the brand name Effexor
342. Verapamil Hydrochloride—Marketed under the brand names Covera-HS and Verelan
343. Voriconazole—Marketed under the brand name VFEND
344. Zaleplon—Marketed under the brand name Sonata
345. Ziprasidone Hydrochloride—Marketed under the brand name Geodon
346. Zolmitriptan—Marketed under the brand name Zomig
347. Zolpidem Tartrate—Marketed under the brand name Ambien
348. Zonisamide—Marketed under the brand name Zonegran

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WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

ROSE CASADO, *Applicant,* vs. **KAISER PERMANENTE, permissibly self-insured, administered by SEDGWICK,** *Defendants.*	**Case No. ADJ9642652 (Riverside District Office)** **OPINION AND DECISION AFTER RECONSIDERATION**

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

Applicant seeks reconsideration of the Findings and Award (F&A) issued by the workers' compensation administrative law judge (WCJ) on February 1, 2018. By the F&A, the WCJ found that applicant sustained injury arising out of and in the course of employment (AOE/COE) to her cervical spine, shoulders and wrists, and the injury resulted in 10% permanent disability. The WCJ further found, in relevant part, that applicant had not shown good cause to strike the report of the panel qualified medical evaluator (QME).

Applicant contends that the QME's report is inadmissible because the QME did not disclose the name and qualifications of the individual who measured applicant with the Jamar dynamometer. She also contends that the QME's permanent impairment ratings are not substantial evidence because he applied an incorrect legal theory and the record must be further developed.

We received an answer from defendant. The WCJ filed a Report and Recommendation on Petition for Reconsideration (Report) recommending that we deny reconsideration.

We have considered the allegations of applicant's Petition for Reconsideration, defendant's answer and the contents of the WCJ's Report with respect thereto. Based on our review of the record and

for the reasons discussed below, we will rescind the F&A and return this matter to the trial level for further proceedings consistent with this opinion.

FACTUAL BACKGROUND

Applicant claims injury to her cervical spine, shoulders, arms and wrists from August 22, 2007 through September 10, 2014 while employed as a pharmacist for Kaiser Permanente. Defendant has accepted liability for the cervical spine, shoulders and wrists, but denied injury to the arms.

Treatment was obtained by applicant with the primary treating physician (PTP), Edwin Haronian, M.D. Her condition was declared permanent and stationary by Dr. Haronian in his January 2, 2017 report with permanent impairment ratings provided to the cervical spine, bilateral wrists, bilateral shoulders and right elbow. (Applicant's Exhibit No. 1, Report of Edwin Haronian, M.D., January 2, 2017, pp. 10, 12-13.)

Ronny Ghazal, M.D., evaluated applicant as the orthopedic panel QME. Dr. Ghazal found applicant's orthopedic condition to be permanent and stationary in his May 27, 2016 report. (Defendant's Exhibit C, Report of Ronny Ghazal, M.D., May 27, 2016, p. 16.) A summary of the physical examination of applicant includes upper extremity measurements and states that "Jamar grip strength maximums are measured on the second notch of the dynamometer and are expressed in pounds." (*Id.* at p. 15.) Dr. Ghazal opined that applicant's injury to the neck, bilateral shoulders and bilateral wrists/hands was caused by cumulative trauma to September 10, 2014. (*Id.* at p. 17.) However, Dr. Ghazal found no ratable impairment for her cervical spine, bilateral wrists or hands. (*Id.* at pp. 16-17.) He provided a 4% whole person impairment (WPI) rating for the bilateral shoulders and referred to "the attached formal Impairment Rating Report." (*Id.* at p. 16.) No work restrictions were provided by Dr. Ghazal. (*Id.*) Page 18 of the report states the following as part of the declaration: "[v]ital signs and extremity measurements were obtained by my medical assistants. I conducted the physical examination, reviewed the provided medical records, then formulated and dictated this report." (*Id.* at p. 18.)

The matter initially proceeded to trial on April 18, 2017 on several issues including in pertinent part: parts of the body injured, permanent disability and the substantiality of medical reports. (Minutes

of Hearing and Summary of Evidence, April 18, 2017, p. 2.) The matter was to be referred to the Disability Evaluation Unit (DEU) and the parties given time to object to the rating and request cross-examination of the Disability Evaluator before the matter would be submitted. (*Id.* at p. 11.) On the trial date, applicant filed a trial brief wherein she contended that Dr. Ghazal's report was not substantial evidence and that Dr. Haronian's findings regarding permanent impairment should be used to rate applicant's permanent disability.

On May 8, 2017, the WCJ issued an Order Vacating Disposition and Further Order of Disposition noting that the formal Impairment Rating Report referred to by the QME Dr. Ghazal in his May 27, 2016 report was not included in the exhibit filed with the Appeals Board. Accordingly, the parties were ordered "to cooperate in obtaining and filing Dr. Ghazal's 'Impairment Rating Report' within 30 days." (Order Vacating Disposition and Further Order of Disposition, May 8, 2017.)

Dr. Ghazal was subsequently deposed by applicant on October 5, 2017. (Joint Exhibit Y, Deposition of Dr. Ghazal, October 5, 2017.) During the deposition, the following exchange took place:

> Q. . . . What body parts were examined for Ms. Casado; do you remember?
>
> A. Everything that is in the report I did except for the vital signs and the girth measurements of the extremities and how many inches her circumference, her forearm and her biceps are; those are the only things I made measures [*sic*].
>
> Q. Okay.
>
> A. So that would be on page 15 where it says "Upper extremity measurements, circumference measured in inches," she did the Jamar grip strength measurements and the dynamometer and where it says "grip strength" that's the right, left and that's circumference right, left, biceps, forearm, that's it, and the vital signs so those are the only things that she did.
>
> Q. Okay. Thank you.
>
> So you mentioned the Jamar dynamometer – I'm not sure I'm pronouncing that correctly – that's as you stated on page 15.
>
> Can you tell us the name of the assistant who assisted you with the measurements?
>
> A. I have no idea. There's three of them that work with me and any one of the three could have done it.

(*Id.* at pp. II-6:25 to II-7:22.) Dr. Ghazal further testified regarding his impairment ratings as follows:

> A. So that's basically what a zero rating in impairment means. It's like I can't really give you a disability based on the fact that your symptoms are all subjective in nature and I find no objective evidence to substantiate your complaints, meaning if you tell me you have this and this and this and this wrong with you or if you tell me you have nothing wrong with you and I evaluate you I'm going to find exactly the same thing; and that's where I end up with no ratable impairment.

(*Id.* at p. II-12:10-18.) He also stated:

> A. . . . So I'm not going to give her a ratable impairment when she has zero objective findings. I don't care how high her subjective complaints are. That's the bottom line.
>
> We can go through this as much as you want. Her rating is zero because her objective findings are not present. Her MRI findings are normal, absolutely normal MRI findings that are appropriate for her age and her nerve conductions study is negative and she's getting zero percent impairment and we can ask these facts of how much it bothers her life and how it impairs her, add item to item and she's going to get the zero impairment rating from me forever. And you have to find one of those applicant guys who has no conscience and he will give her a higher impairment rating than me and then you go to court and you figure it out.
>
> So basically if you want a fair objective evaluation she gets zero impairment because she's just subjective [*sic*] complaints.

(*Id.* at p. II-25:1-19.) Finally, at the end of the deposition, Dr. Ghazal testified that:

> Q. And since you had no impairment – since you find no impairment using any other table in the AMA guides, isn't this a perfect case where, say, a rating using the strength on – the loss of strength due to the applicant's impairment?
>
> A. No. In my opinion this patient has all subjective complaints and she is not eligible for an impairment rating in any way that you want to measure impairment. If I thought that there was – this lady deserved a ratable impairment for her subjective complaints, I could have used Almaraz-Guzman and given her one.
>
> I can – I have the authority under Work Comp standards to issue an impairment rating even if it doesn't fit into the book because of case law. And in this case I thought this was the appropriate impairment rating.

(*Id.* at pp. II-42:24 to II-43:14.)

/ / /

On October 16, 2017, applicant filed a Petition to Strike the QME Report of Dr. Ghazal as inadmissible for violation of Labor Code section 4628 and that the report is not substantial evidence. (Lab. Code, § 4628.)[1]

The matter proceeded to trial again on December 28, 2017, at which time the missing Impairment Rating Report and Dr. Ghazal's deposition transcript were admitted as joint exhibits and the matter was again referred to the DEU. (Minutes of Hearing and Summary of Evidence, December 28, 2017, pp. 1-2.) On January 19, 2018, the WCJ sent rating instructions to the DEU requesting a rating of Dr. Ghazal's May 27, 2016 report. Applicant filed a Motion to Strike Rating on January 25, 2018 alleging that Dr. Ghazal's findings on impairment are insufficient.

In the resulting F&A, the WCJ found that applicant's injury had caused 10% permanent disability based on Dr. Ghazal's impairment rating for the shoulders. Although the WCJ found injury AOE/COE to the cervical spine and wrists in addition to the shoulders, no permanent disability was provided for these body parts pursuant to Dr. Ghazal's opinions. The WCJ further found that applicant had not shown good cause to strike the panel QME report of Dr. Ghazal. Dr. Haronian's opinions were not considered substantial evidence by the WCJ in his Opinion on Decision.

DISCUSSION

I.

Section 4628 provides as follows for medical-legal reports:

> (b) The report shall disclose the date when and location where the evaluation was performed; that the physician or physicians signing the report actually performed the evaluation; whether the evaluation performed and the time spent performing the evaluation was in compliance with the guidelines established by the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 and shall disclose the name and qualifications of each person who performed any services in connection with the report, including diagnostic studies, other than its clerical preparation . . .
>
> . . .
>
> (e) Failure to comply with the requirements of this section shall make the report inadmissible as evidence and shall eliminate any liability for

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

> payment of any medical-legal expense incurred in connection with the report.

(Lab. Code, § 4628(b) and (e).) WCAB Rule 10606 provides a list of items that should be included in medical reports where applicable and specifies that:

> All medical-legal reports shall comply with the provisions of Labor Code Section 4628. Except as otherwise provided by the Labor Code, including Labor Code Sections 4628 and 5703, and the rules of practice and procedure of the Appeals Board, failure to comply with the requirements of this section will not make the report inadmissible but will be considered in weighing the evidence.

(Cal. Code Regs., tit. 8, § 10606(c).)

The WCJ relied on the rating provided in Dr. Ghazal's May 27, 2016 report to award applicant 10% permanent disability. Section 4628(b) requires a physician to disclose the name and qualifications of each person who performed any services in connection with a medical-legal report. However, Dr. Ghazal's report does not identify the person who performed the grip strength testing and Jamar dynamometer measurements as part of his evaluation. His report simply identifies his "medical assistants" as performing the extremity measurements. Dr. Ghazal was unable to clarify which of his assistants performed these measurements during his deposition. Accordingly, his May 27, 2016 report violates section 4628(b) and is inadmissible as evidence pursuant to section 4628(e).

Therefore, the F&A may not be supported by Dr. Ghazal's May 27, 2016 report because the report is inadmissible as evidence.

II.

It is well established that decisions by the Appeals Board must be supported by substantial evidence. (Lab. Code, §§ 5903, 5952(d); *Lamb v. Workmen's Comp. Appeals Bd.* (1974) 11 Cal.3d 274 [39 Cal.Comp.Cases 310]; *Garza v. Workmen's Comp. Appeals Bd.* (1970) 3 Cal.3d 312 [35 Cal.Comp.Cases 500]; *LeVesque v. Workmen's Comp. Appeals Bd.* (1970) 1 Cal.3d 627 [35 Cal.Comp.Cases 16].) To constitute substantial evidence ". . . a medical opinion must be framed in terms of reasonable medical probability, it must not be speculative, it must be based on pertinent facts and on an adequate examination and history, and it must set forth reasoning in support of its conclusions."

1 (*Escobedo v. Marshalls* (2005) 70 Cal.Comp.Cases 604, 621 (Appeals Board en banc).) "Medical
2 reports and opinions are not substantial evidence if they are known to be erroneous, or if they are based
3 on facts no longer germane, on inadequate medical histories and examinations, or on incorrect legal
4 theories. Medical opinion also fails to support the Board's findings if it is based on surmise, speculation,
5 conjecture or guess." (*Hegglin v. Workmen's Comp. Appeals Bd.* (1971) 4 Cal.3d 162, 169 [36
6 Cal.Comp.Cases 93, 97].)

7 The Appeals Board has the discretionary authority to develop the record when the medical record
8 is not substantial evidence or when appropriate to provide due process or fully adjudicate the issues.
9 (Lab. Code, §§ 5701, 5906; *Tyler v. Workers' Comp. Appeals Bd.* (1997) 56 Cal.App.4th 389 [62
10 Cal.Comp.Cases 924]; see *McClune v. Workers' Comp. Appeals Bd.* (1998) 62 Cal.App.4th 1117 [63
11 Cal.Comp.Cases 261].) In our en banc decision in *McDuffie v. Los Angeles County Metropolitan Transit*
12 *Authority* (2001) 67 Cal.Comp.Cases 138 (Appeals Board en banc), we stated that "[s]ections 5701 and
13 5906 authorize the WCJ and the Board to obtain additional evidence, including medical evidence, at any
14 time during the proceedings (citations) [but] [b]efore directing augmentation of the medical record . . .
15 the WCJ or the Board must establish as a threshold matter that specific medical opinions are deficient,
16 for example, that they are inaccurate, inconsistent or incomplete." (*McDuffie, supra,* at p. 141.) The
17 preferred procedure is to allow supplementation of the medical record by the physicians who have
18 already reported in the case. (*Id.*)

19 Dr. Ghazal's May 27, 2016 report is inadmissible pursuant to the analysis above. However, the
20 findings of the PTP Dr. Haronian were not found to be substantial evidence by the WCJ. Consequently,
21 there is no medical reporting in the current record that can be relied on to address some of the disputed
22 issues at trial. The record must accordingly be further developed. The preferred procedure is to allow
23 supplementation of the record by the physicians who have already reported on this case. Although one of
24 Dr. Ghazal's reports is inadmissible, he remains the QME on this matter. Thus, further development of
25 the record should include, at a minimum, a supplemental report from Dr. Ghazal that complies with
26 section 4628.

27 Therefore, we will return this matter to the trial level for further development of the record.

III.

For injuries occurring on or after January 1, 2013, like applicant's claim, section 4660.1 provides for determination of permanent disability as follows:

> (a) In determining the percentages of permanent partial or permanent total disability, account shall be taken of the nature of the physical injury or disfigurement, the occupation of the injured employee, and his or her age at the time of injury.
>
> (b) For purposes of this section, the "nature of the physical injury or disfigurement" shall incorporate the descriptions and measurements of physical impairments and the corresponding percentages of impairments published in the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th Edition) with the employee's whole person impairment, as provided in the Guides, multiplied by an adjustment factor of 1.4.
>
> . . .
>
> (d) . . . The Schedule for Rating Permanent Disabilities pursuant to the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th Edition) and the schedule of age and occupational modifiers shall be available for public inspection and, without formal introduction in evidence, shall be prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule. Until the schedule of age and occupational modifiers is amended, for injuries occurring on or after January 1, 2013, permanent disabilities shall be rated using the age and occupational modifiers in the permanent disability rating schedule adopted as of January 1, 2005.
> (Lab. Code, § 4660.1(a)-(b) and (d).)

An en banc decision of the Appeals Board outlined the roles of both the physician and the WCJ in determining permanent impairment. (*Blackledge v. Bank of America* (2010) 75 Cal.Comp.Cases 613 (Appeals Board en banc). The "physician's role is to assess the injured employee's whole person impairment percentage(s) by a report that sets forth facts and reasoning to support its conclusions and that comports with the AMA Guides and case law." (*Id.* at p. 615.) *Blackledge* panel further specified that "to constitute substantial evidence regarding WPI a physician's opinion must comport with the AMA Guides, including as applied and interpreted in published appellate opinions and en banc decisions of the Appeals Board." (*Id.* at p. 620.)

Pursuant to section 4660.1(d), the scheduled rating is prima facie evidence of an employee's permanent disability. However, the scheduled rating is rebuttable. (*Milpitas Unified School Dist. v.*

Workers' Comp. Appeals Bd. (*Almaraz-Guzman III*) (2010) 187 Cal.App.4th 808 [75 Cal.Comp.Cases 837, 852-853].) Specifically, the WPI portion of the scheduled rating may be rebutted by showing that "a different chapter, table, or method of assessing impairment of the AMA Guides more accurately reflects the injured employee's impairment than the chapter, table, or method used by the physician being challenged." (*Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School Dist.* (*Almaraz-Guzman II*) (2009) 74 Cal.Comp.Cases 1084, 1106 (Appeals Board en banc).)[2] Physicians must still evaluate permanent impairment while staying within the "four corners of the Guides" pursuant to the Labor Code. (*Id.* at p. 1101.)

The overarching goal of rating permanent impairment is to achieve accuracy. (*Almaraz-Guzman III, supra.*) A "strict" application of the Guides may not accurately reflect an injured employee's permanent impairment. The Guides expressly recognizes its limitations in Chapter 1:

> Given the range, evolution, and discovery of new medical conditions, the Guides cannot provide an impairment rating for all impairments. Also, since some medical syndromes are poorly understood and are manifested only by subjective symptoms, impairment ratings are not provided for those conditions. The Guides nonetheless provides a framework for evaluating new or complex conditions.

(AMA Guides, p. 11.) The en banc panel in *Almaraz-Guzman II* acknowledged this and specifically held that

> . . . while the AMA Guides often sets forth an analytical framework and methods for a physician in assessing WPI, the Guides does not relegate a physician to the role of taking a few objective measurements and then mechanically and uncritically assigning a WPI that is based on a rigid and standardized protocol and that is devoid of any clinical judgment. Instead, the AMA Guides expressly contemplates that a physician will use his or her judgment, experience, training, and skill in assessing WPI.

(*Almaraz-Guzman II, supra*, at pp. 1103-1104.)

The AMA Guides is thus not to be literally and mechanically applied. Instead, the evaluating physician may use his or her experience and expertise to interpret and apply any portion of the entire AMA Guides. A physician who departs from a strict application of the AMA Guides must explain why

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[2] The "AMA Guides" or "Guides" refers to the American Medical Association Guides to the Evaluation of Permanent Impairment, 5th Edition (2001).

the departure is necessary and how the WPI rating was derived. (*Almaraz-Guzman III*, *supra*, at p. 854.) Consequently, although the evaluating physician may utilize the chapter, table or method in the AMA Guides "that most accurately reflects the injured employee's impairment," the physician's "opinion must constitute substantial evidence upon which the WCAB may properly rely, including setting forth the reasoning behind the assessment." (*Almaraz-Guzman II*, *supra*, at p. 1104.)

In *City of Sacramento v. Workers' Comp. Appeals Bd.* (*Cannon*) (2013) 222 Cal.App.4th 1360, the Court of Appeal addressed whether a physician could provide a permanent impairment rating utilizing *Almaraz-Guzman* based purely on the employee's subjective complaints without objective findings. The police officer in *Cannon* had plantar fasciitis, which has no standard rating in the AMA Guides, but caused the officer to have heel pain. The agreed medical evaluator (AME) provided a WPI rating by analogy to a limp (gait derangement abnormality) due to the heel causing weightbearing problems. (*Id.* at p. 1365.) The City of Sacramento argued that his condition could not be rated by analogy under *Almaraz-Guzman* in the absence of objective findings and where the rating is based solely on subjective complaints. (*Id.* at p. 1366.) The Court rejected the City's argument holding that the AME's rating by analogy was permissible and concluded that nothing in the statute "precludes a finding of impairment based on subjective complaints of pain where no objective abnormalities are found." (*Id.* at p. 1371.)[3]

As discussed above, a medical opinion based on an incorrect legal theory is not substantial evidence. (*Hegglin*, *supra*.) In the instant matter, portions of Dr. Ghazal's testimony suggest that because applicant has no positive objective findings, he will not provide an impairment rating greater than zero based on her subjective complaints. However, the *Cannon* Court specifically opined that the Labor Code does not preclude a finding of impairment based on subjective complaints even in the

[3] We acknowledge that the *Almaraz-Guzman* decisions and *Cannon* analyzed section 4660 rather than section 4660.1, which is applicable to the instant matter. However, section 4660.1(b) is identical to section 4660(b)(1) with the exception of the additional language of "...with the employee's whole person impairment, as provided in the Guides, multiplied by an adjustment factor of 1.4." Moreover, section 4660.1(h) expressly states that "In enacting the act adding this section, it is not the intent of the Legislature to overrule the holding in *Milpitas Unified School District v. Workers' Comp. Appeals Bd.* (*Guzman*) (2010) 187 Cal.App.4th 808." (§ 4660.1(h).)

absence of objective findings. Accordingly, a physician may provide an impairment rating greater than zero based solely on subjective complaints if he or she finds that alternate rating to most accurately reflect the injured employee's impairment.

The evaluating physician thus may provide a rating by analogy to another chapter, table or method in the AMA Guides where the impairment rating would otherwise be zero pursuant to the case law discussed above. However, a rating of zero may accurately reflect an injured employee's permanent impairment in some cases. As outlined above, the physician is expected to utilize his or her "judgment, experience, training, and skill in assessing WPI" in order to provide a rating that accurately reflects the injured employee's permanent impairment and provide the reasoning behind the assessment in order for the rating to be relied on as substantial evidence.

Dr. Ghazal acknowledged at the end of his deposition that he may provide an impairment rating for applicant's subjective complaints pursuant to *Almaraz-Guzman*. He further testified that he may "issue an impairment rating even if it doesn't fit into the book because of case law." It is unclear from this statement if Dr. Ghazal understands that he may use any table, chapter or method of the AMA Guides to provide a more accurate impairment rating pursuant to *Almaraz-Guzman* or if he believes he may go outside the Guides to assign an impairment rating. To the extent this statement reflects the latter belief, this is an inaccurate understanding of the law.

Portions of Dr. Ghazal's deposition testimony indicate that he was evaluating impairment based on an incorrect legal theory, i.e., applicant's impairment rating can only be zero if there are no objective findings or the physician may go outside the Guides to provide an impairment rating. We consequently agree with applicant that his opinions are not substantial evidence to the extent that he may have relied on an incorrect legal theory. Applicant requests appointment of an independent medical evaluator (IME) or a new QME panel for further development of the record. However, as discussed above, the preferred procedure to develop a deficient record is to return the injured worker to the physicians that have already reported in the matter. We can discern no basis to strike Dr. Ghazal as the panel QME and recommend further development of the record to include a supplemental report from Dr. Ghazal. This would allow

Dr. Ghazal to remedy the deficiency under section 4628 addressed above and ensure an evaluation of applicant's level of permanent impairment in accordance with the correct legal principles.

In conclusion, we will rescind the F&A and return this matter to the trial level for further proceedings consistent with this opinion.

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For the foregoing reasons,

IT IS ORDERED as the Decision After Reconsideration of the Workers' Compensation Appeals Board that the Findings and Award issued by the WCJ on February 1, 2018 is **RESCINDED** and the matter **RETURNED** to the trial level for further proceedings consistent with this opinion.

WORKERS' COMPENSATION APPEALS BOARD

DEPUTY

JOHN F. SHIELDS

I CONCUR,

CHAIR

KATHERINE ZALEWSKI

DEIDRA E. LOWE

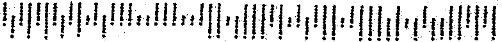
DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

AUG 2 3 2018

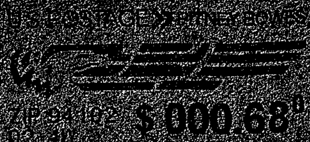
SERVICE MADE ON THE ABOVE DATE ON THE PERSONS LISTED BELOW AT THEIR ADDRESSES SHOWN ON THE CURRENT OFFICIAL ADDRESS RECORD.

HANNA, BROPHY, MACLEAN, MCALEER & JENSEN
LAW OFFICE OF AU LANG
ROSE ALLAINE CASADO

AI:mm



DEPT OF
WORKERS COMPENSATION APPEALS BOARD
OFFICE OF THE COMMISSIONERS
PO BOX 429459
SAN FRANCISCO CA 94142 9459



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Robert Nava & Bret Graham

Commerce Plaza, Ste. 301
420 N. Montebello Blvd.
Montebello, CA 90640

TEL: (323) 888-1818
FAX: (323) 888-7788

CAAA WINTER CONVENTION 2019 – MEDICARE SET-ASIDE (MSA)

1. **REVIEW MEDICARE SET-ASIDE (MSA) PROPOSAL:**
   - A. **Was it already approved by CMS?**
   - B. **Submit or non-submit**
   - C. **What does it cover ?**
     - i. **What body parts/conditions**
     - ii. **Treatment modalities**
     - iii. **Diagnostics**
     - iv. **Medications**
   - D. **Not covered:**
     - i. **Denied body parts/conditions**
     - ii. **UR/IMR denials – when was RFA (1 year rule; less if new doctor)**
2. **EVALUATE THE FUTURE MEDICAL NEEDS *NOT* COVERED BY MEDICARE:**
   - A. **Co-pays and annual deductibles (is applicant on Medi-Cal?)**
   - B. **Transportation/mileage**
   - C. **Interpreter**
   - D. **In-home care**
   - E. **Other**
3. **CALCULATE THE REAL TOTAL COST OF FUTURE MEDICAL CARE**
   - A. **Get the medical benefit printout.**
   - B. **Add Items 1B (the MSA itself) + 1C (care not in MSA) + 2A-E(non-Medicare items) for the TOTAL FUTURE MEDICAL COST**
   - C. **Verify independently that the figures assigned are accurate – can your client actually obtain the services for that cost. This may mean hiring a life care planner, nurse case manager or doing the research yourself.**
4. **DOES PROFESSIONAL ADMINISTRATION MAKE SENSE ?**
   - A. **Is the applicant capable of self-administering ? Hint – no.**
   - B. **Cost savings due to professional administration !**
   - C. **Calculate the revised (lower) total cost of medical care.**
5. **USE THE POWER OF STRUCTURED SETTLEMENT ANNUITY:**
   - A. **Tailor payment streams to match medical needs**
   - B. **Know what it costs to fund structure to meet medical needs**
     - i. **MSA**
     - ii. **Non-MSA future medicals**
   - C. **Estate planning with guarantees/non-reversionary MSA funds**
6. **GO BACK TO DEFENDANTS TO RENEGOTIATE C&R AMOUNT**
   - A. **Knowledge of your real bottom line**
   - B. **Additional medical/non-medical data to increase NON-MSA future medical value.**
   - C. **Updated medicals to decrease MSA to achieve a palatable number (?)**
   - D. **Is this a CIGA case**

State Compensation Insurance Fund
Subpoena Status Request Form

State Fund's Subpoena Request Fax #: 916-924-5136

Help us to help you!

In order to receive a response, the information below is mandatory:

Name of Copy Service: Med-Legal

Date subpoena was served and accepted by State Fund: 1/17/19

Name of person you're seeking records on: Laura Alfino.

State Fund Claim Number: sl186035

Reference # on Subpoena: 18-46622-1

Status of Subpoena: *(to be filled out by State Fund)*

__ The records were mailed back to you on: ________

X This subpoena has been entered and is "In Process"

__ This subpoena has been objected to, and has been "No Actioned". You will receive a copy of our objection via Proof of Service.

__ This subpoena is for a "hybrid" claim (old date of injury). The electronic portion has been printed, and we are waiting for the paper component to be completed.

__ We have no record of receiving a subpoena from your company.

__ The subpoena has been entered, but not assigned to an attorney for review yet.

Return Fax Number to Copy Service: 800-962-4896

**If you do not know the State Fund claim number, please call 1-888-State Fund (1-888-782-8338) with identifying information to get the claim number before you submit your request.

Your cooperation will ensure a timely response from State Compensation Insurance Fund.

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WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

CHRISTOPHER DEVEREUX, *Applicant,* vs. **STATE COMPENSATION INSURANCE FUND, Permissibly Self-Insured; administered by THE HARTFORD,** *Defendants.*	**Case No. ADJ10307426 (Sacramento District office)** **OPINION AND ORDERS DENYING AND GRANTING PETITIONS FOR RECONSIDERATION AND DECISION AFTER RECONSIDERATION**

11 Applicant Christopher Devereux, and defendant State Compensation Insurance Fund, permissibly
12 self-insured, seek reconsideration of the Findings and Award, issued September 19, 2018, in which a
13 workers' compensation administrative law judge (WCJ) found applicant sustained 90% permanent
14 disability as a result of an admitted industrial cumulative trauma injury in the form of hypertension,
15 diabetes, heart, circulatory, and cognitive impairment, without apportionment, over the period ending
16 August 15, 2015, while employed as an attorney.

17 Defendant challenges the permanent disability rating, contending the WCJ erred in using the
18 addition method to calculate applicant's permanent disability from his cognitive and cardiac/hypertension
19 impairments, rather than using the Combined Value Chart (CVC), due to the absence of overlapping
20 disability. Defendant argues that using the CVC is the proper method for combining applicant's
21 impairments in the absence of medical evidence of a synergistic effect between them.

22 Applicant seeks reconsideration to correct two errors in the Findings and Award, specifically to
23 provide for annual increases in permanent disability based on increases in the state average weekly wage
24 per Labor Code section 4659(c), and to award future medical treatment for all of applicant's industrially
25 injured body parts, and not just for hypertension/heart and sexual dysfunction, as was provided in Finding
26 of Fact number 7.

27 We have received applicant's Answer to defendant's Petition for Reconsideration, and have

reviewed the WCJ's Report and Recommendation on Petition for Reconsideration, in which she recommends that we grant applicant's Petition for Reconsideration to amend the Findings and Award to provide for permanent disability increases pursuant to Labor Code section 4659(c), and to correct the award of future medical treatment. With regard to defendant's Petition for Reconsideration, the WCJ presents additional analysis to justify her determination to add rather than combine applicant's impairments.

For the reasons set forth below, we will follow the WCJ's recommendation with regard to applicant's Petition for Reconsideration, and will grant reconsideration to amend the Findings and Award as recommended. We will also affirm the WCJ's permanent disability rating and will deny defendant's Petition for Reconsideration.

I.

While employed as an attorney by State Compensation Insurance Fund, applicant sustained an admitted industrial injury in the form of hypertension, diabetes, heart, circulatory, and cognitive impairment, over the period ending August 15, 2015.

Applicant was evaluated by Dr. Raye Bellinger, the Qualified Medical Evaluator (QME) in cardiology, and Dr. Claude Munday, the QME in neuropsychology.

Dr. Bellinger found applicant sustained an injury to his heart and hypertension as a result of "a harsh/stressful workplace" handling high profile cases, for which applicant sustained a 30% whole person impairment under the AMA Guides.

> The 30% impairment arises out of specific language in the AMA Guides under Class Ill noting that if patients have left ventricular hypertrophy by ECG, they rate a minimum of 30% (Table 4-2, Page 66).

In response to questions from counsel, Dr. Bellinger indicated that applicant's cardiac impairment was separate and distinct from the cognitive impairment identified by Dr. Munday.

> The cognitive impairment although related to the treatment of his hypertension (according to Dr. Munday) is a separate and distinct injury that is not directly related to the effects of the hypertension per se.
>
> I would absolutely agree that the most accurate rating in this case would be to add my impairment rating to that given by Dr. Munday.
>
> I also agree that my impairment and Dr. Munday's impairment are separate impairments and do not require the Combined Values Chart.

In a subsequent report, Dr. Bellinger responded to questions from defendant's counsel regarding overlapping impairments:

> Ms. Shannon also asked that since it is the cardiac medications, which are causing the cognitive impairment, "you have already provided your opinion of 30% whole person impairment for the hypertension, is the cognitive dysfunction really overlapping the hypertension impairment or is it subsumed within the impairment rating you found of 30%. If you feel the cognitive impairment is separate from the permanent disability you found, please discuss why. In addition, if you feel a separate impairment, do you feel the same apportionment you gave should apply to the whole person impairment to cognitive dysfunction?"
>
> My impairment calculation might be only accounted for the hypertensive component and not for cognitive dysfunction as a secondary effect of treatment of hypertension. I defer the actual cognitive evaluation be left to Dr. Munday who is an expert in neuropsychology. However, I feel both of these impairments are separate and distinct. Hypertension is based on the development of left ventricular hypertrophy as opined above and cognitive dysfunction is a secondary effect of the medication use for treatment. . . .
>
> . . .
>
> Ms. Shannon also states "applicant's attorney suggested in his letter of September 25, 2017, that a more accurate rating would be to simply add your impairment with that given by Dr. Munday. If the 48% is added to 33%, the result is 81% permanent disability. Is this very high level of permanent disability, a reasonable and accurate permanent disability rating applicable to Mr. Devereux in this case? If not, please discuss and provide the accurate impairment rating. If so, please discuss in detail your reasoning and authority for stacking the rating rather than using the standard method of combining permanent disability, found in the Schedule."
>
> . . .
>
> I find it completely appropriate to simply add my rating of 30% for hypertension followed to Dr. Munday's 14%, both adjusted in apportionment of 90%, given the level of injury Mr. Devereux has suffered. The rating of 30% is "black letter" writing out of the AMA Guides. Dr. Munday is responsible for his own rating and defense of such rating. I found Dr. Munday's evaluation to be reasonable and appropriate.

Dr. Munday found the four anti-hypertensive medications required to treat applicant's hypertension were the cause of his cognitive dysfunction, noting: "the specific picture of pronounced slowness and decreased attention/concentration/working memory is most consistent with medication effects, particularly medicines that are somewhat sedating." He diagnosed applicant with Substance/Medication Induced Mild Neurocognitive Disorder.

Dr. Munday noted applicant suffered impairments in memory, and in judgment and problem solving.

When asked to comment about "the proper combining of cardiovascular issues rated by Dr. Bellinger and the neurocognitive rated by the undersigned," Dr. Munday stated:

> Frankly, when we are dealing with mental impairments and physical impairments, in terms of the ultimate disability there often is not much in the way of overlap. It is my perspective that these two impairments that are discrete and in very different areas are best combined through a strict adding procedure than anything else. I do not have a basis to argue that they are synergistic to any significant degree. That is, I would not argue that the actual disability is greater than the simple additive combining of the impairments.

On this record, the WCJ determined that applicant's combined permanent disability rating, from the WPI ratings of Dr. Bellinger and Dr. Munday, should be based upon adding the impairments rather than using the CVC, in view of the physicians' opinions that this was most appropriate in the absence of overlapping impairments.

II.

Defendant challenges the WCJ's determination that the medical record supports using the additive method over the CVC for combining applicant's two separately rated impairments. Defendant contends that the law requires the WCJ to use the CVC absent rebuttal evidence showing a "synergistic effect" between the impairments. Applicant counters that the permanent disability rating schedule applicable to injuries sustained after January 1, 2013, no longer mandates the use of the CVC, and that the method for combining impairments must be decided on the medical evidence on a case by case basis.

The rating schedule provides that the CVC is "generally" used to combine multiple disabilities, but that other methodology may be used depending upon the relevant circumstances. It is the role of the medical expert to make a medical determination as to how to combine the separate impairments. One reason for using the CVC is to avoid combining impairments that lead to a rating greater than 100% permanent disability. However, this concern is not justified here, since applicant cannot receive a permanent disability award for a single injury greater than 100%.

We do not concur with defendant's contention that absent effective rebuttal evidence of a

"synergistic effect" between the impairments, use of the CVC chart is mandated. Multiple cases have held that this determination is best based upon the extent to which the impairments affect applicant's ability to perform activities of daily living. It is the opinions of the medical evaluators and not a rigid application of the CVC in the rating schedule that should prevail. (*Athens Administrators v. Workers' Comp. Appeals Bd.* (*Kite*) (2013) 78 Cal.Comp.Cases 213, [appropriate to use additive approach because AMA Guides describe several methods of combining impairments and rigid application of CVC is not mandated]; *Los Angeles County Metropolitan Transportation Authority v. Workers' Comp. Appeals Bd.* (*La Count*) (2015) 80 Cal.Comp.Cases 470, [proper to add impairments rather than use CVC in light of AME opinion that there was synergistic effect to orthopedic injuries so that they should be added rather than combined]; *Diaz v. State*, 2015 Cal. Wrk. Comp. P.D. LEXIS 683, [additive approach within the authority of WCJ because there was no clear overlap in impairments]; *Sanchez v. California Dept., of Corrections*, 2015 Cal. Wrk. Comp. P.D. LEXIS 482, [additive rating may be used when combining multiple impairments results in more accurate rating of overall permanent disability].)

It has been recognized that a disability rating, "should reflect as accurately as possible an injured employee's diminished ability to compete in the open labor market." (*LeBoeuf v. Workers' Comp. Appeals Bd.* (1983) 34 Cal.3d 234, 245-246 [48 Cal.Comp.Cases 587].) In this case, the WCJ reasonably concluded that the medical evaluators properly determined that adding the hypertension and cognitive impairment disabilities more accurately reflects applicant's entire permanent disability than results from using the CVC.

While we do not endorse applicant's and the WCJ's analysis that the post-2013 permanent disability rating schedule eliminated the reliance on the CVC, we do find the WCJ properly found the reports of Dr. Munday and Dr. Bellinger constitute substantial medical evidence that adequately support the use of the addition method here.

Accordingly, we will affirm the WCJ's 90% permanent disability rating, and will deny defendant's Petition for Reconsideration.

Additionally, we will grant applicant's Petition for Reconsideration, as recommended by the WCJ, to correct the errors in the award with regard to the award of future medical treatment, and applicant's

entitlement to increases pursuant to Labor Code section 4659(c).

For the foregoing reasons,

IT IS ORDERED that Defendant's Petition for Reconsideration, filed October 9, 2018, is **DENIED**.

IT IS FURTHER ORDERED that Applicant's Petition for Reconsideration, filed October 15, 2018, is **GRANTED**, and as our Decision After Reconsideration, the September 19, 2018 Findings and Award is **AMENDED** as follows:

FINDINGS OF FACT

7. Future medical treatment to cure or relieve applicant from the effects of the industrial injury.

AWARD

AWARD IS MADE in favor of **CHRISTOPHER DEVEREUX**, and **STATE COMPENSATION INSURANCE FUND**, as follows:

a) Permanent disability in the amount of 90% payable at the rate of $290.00 per week beginning August 30, 2017 for 753.25 weeks totaling $218,442.50 plus life pension thereafter at the rate of $231.92 per week and subject to the increases pursuant to Labor Code 4659(c), less credit for permanent disability advances paid to date and less attorney fees per Finding No. 8 above payable to Marcus, Regalado & Marcus. The parties are to obtain a commutation from the DEU to determine the exact amount of the attorney fees based on the above.

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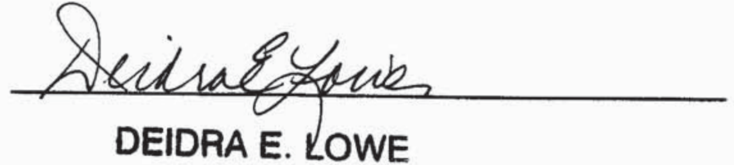
b) Future medical treatment in accordance with Finding of Fact number 7.

WORKERS' COMPENSATION APPEALS BOARD

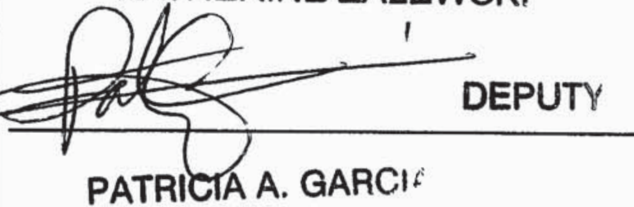


DEIDRA E. LOWE

I CONCUR,

CHAIR

KATHERINE ZALEWSKI



DEPUTY

PATRICIA A. GARCIA

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

DEC 10 2018

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

CHRISTOPHER DEVEREUX
MARCUS, REGALADO & MARCUS
GOLDMAN, MAGDALIN & KRIKES

SV/*pc*

THE DOMINGUEZ FIRM LLP

March 11, 2019

[illegible]
[illegible]
Mira Loma, CA 91752

Re: [illegible]
WCAB No: [illegible]
Claim No: [illegible]
Date of Injury: [illegible]

Dear Dr. [illegible]:

As you are aware this office represents Mr. [illegible] in his workers' compensation case against [illegible].

Thank you for acting as the Panel Qualified Medical Evaluator ("PQME") in the field of [illegible] in the above captioned-matter.

The purpose of this letter is to request a supplemental report addressing impairment under the KITE and LA COUNT ANALYSIS. As you are aware, Mr. [illegible] suffered serious and devastating injuries to different areas. This indicates Mr. [illegible] is more impaired than someone who can compensate with an uninjured area. For this reason, it is more accurate to add the impairments versus the standard of combining impairments.

In ***Athens Administrators v. WCAB (Richard Kite)*** (2013) 78 Cal. Comp. Cases 213, The KITE decision affirms that the 2005 Permanent Disability Rating Schedule provides that impairments are generally combined using the reduction formula, but the AMA Guides don't mandate the use of the Combined Value Chart. A medical opinion is valid as to whether impairment resulting from multiple injuries is most accurately reflected by adding the impairments instead of using the Combined Values Chart.

In ***Los Angeles Metropolitan Transit Authority v. WCAB*** (La Count) (W-D 2015) 80 Cal. Comp Case 470, the LA COUNT case, the court held that the Orthopedic AME's opinion of synergistic effect between the orthopedic injuries and injuries found to Applicant's internal and psyche was sound and thus his decision to add the impairment ratings, rather than combining them using the Combined Values Chart, was an appropriate method of determining the Applicant's overall impairment.

In light of the above, please address whether or not in your professional opinion, you find it appropriate to add impairments due to synergistic effects and increased loss of function due to the various injuries.

When you have completed your report, please send to:

BRADFORD & BARTHEL, LLP
18801 VENTURA BLVD., STE. 200
TARZANA, CA 91356
ATTN. [redacted]

THE DOMINGUEZ FIRM
3250 WILSHIRE BLVD., SUITE 1200
LOS ANGELES, CA 90010
ATTN. MANUEL A. OCAÑA

Kindly submit your billing to:

AIG CLAIMS, INC.
P.O. BOX 25977
SHAWNEE MISSION, KS 66225
ATTN. [redacted]

Thank you for your assistance in this matter.

Very truly yours,

THE DOMINGUEZ FIRM

By:
Manuel A. Ocaña

MAO:ma

cc. Bradford & Barthel Tarzana
18801 Ventura Blvd., Suite 200
Tarzana, CA 91356

II.

WHEN A WORKER SUSTAINS INJURIES THAT ARE NOT OVERLAPPING AND THE TRUE LEVEL OF DISABILITY SUSTAINED IS NOT ACCURATELY REFLECTED USING THE COMBINED VALUES CHART, THE IMPAIRMENTS MAY BE ADDED TO REFLECT THE MOST ACCURATE DISABILITY RATING

In Athens Administrators v. WCAB (Kite), (2013) 78 CCC 213, Cal Wrk. Comp. LEXIS 34, Applicant suffered an admitted bilateral hip injury. The QME issued a report finding applicant had 20% WPI with respect to each hip pursuant to the AMA guides. The QME added the two hips together finding a 40% WPI for both hips. In his report the QME explained that in his opinion, the best way to combine applicant's impairments to the right and left hips would be to add them together as opposed to using the Combine Values Chart, which would result in a lower WPI. The WCJ issued an award of 46% PD based on the opinion of the QME and that adding the two hips together would produce the most accurate reflection of applicant's PD. The WCJ observe there are several different ways disabilities may be combined. Although the 2005 schedule provides that impairments and disabilities are generally combined using the reduction formula, the WCJ pointed out that the 2005 schedule is rebuttable. The WCJ noted that AMA guides express favor toward the combined values method, the multiple disabilities table is a guide and the physician may under certain circumstances employ different method of determining impairment if they remain within the four corners of the guides.

In Martinez v. Pack Fresh Processors, (2017) Cal. Wrk. Comp. P.D. LEXIS 492, Applicant suffered an admitted to her right arm/hand after two surgeries she developed severe reflex sympathetic dystrophy. She subsequently developed psychiatric symptoms. The rehabilitation consultant determined jobs available to the applicant would have include greeter, gate guard, and limited service cashiering positions. However, the rehabilitation consultant noted that "Most of these positions require 'interpersonal interaction' and do not focus upon production activity. The primary activities in these jobs are social, not hand oriented. The difficulty in this case with Ms. Martinez is the pain that she suffers; difficulty with engaging with people and socializing." Martinez, pg. 7.

The WCJ rejected defendant's rehabilitation consultant's conclusions finding that the consultants had fail to consider the applicant's the severe major depression which this woman

suffers, in determining whether she could maintain a work position and she did not take into consideration the pain syndrome which would affect the applicant's ability to use her damaged hand as an assist for her left hand.

In dealing with the psychiatric disabilities the WCJ stated:

> "Th[e] determination [of permanent disability] cannot be made based upon the whole person impairment percentage alone. The physicians, as they did in this case, must spell out the effect of the impairment on the applicant's work life. [*17] Here, the orthopedic impairment affects the use of the right dominant hand finding it effectively useless to the applicant at work. Likewise, the psychiatrics impairments and the associated pain syndrome affect her ability to do the occupations available to similarly situated workers who have lost the use of their upper extremity, i.e. a social engagement type of occupation. It is not usual for an orthopedic surgeon to determine the functional limitations from a psychiatric injury nor is it usual for a psychologist to determine the functional limitations for an orthopedic disability. Thus, they are not able to determine if the limitations overlap or not. However, it is usual for the Board to determine if functional impairments overlap or are added on to other functional impairments. Based on the facts of this case it was determined that the functional impairments were best added rather than combined. (Bolding in original.)

DISCUSSION

For injuries occurring before January 1, 2013, like the June 30, 2011 injury in this case, section 4660 provides for use of the 2005 Permanent Disability Rating Schedule (PDRS) to determine the level of permanent disability. As part of that process, a physician [*18] may, with proper explanation, deviate from the percentages contained in the applicable chapter of the American Medical Association's Guides to the Evaluation of Permanent Impairment, Fifth Edition (AMA Guides) in order to better express the injured worker's level of impairment in light of the physician's skill, knowledge, and experience, as well as considerations unique to the injury and information derived from extrinsic resources. (Almaraz v. Environmental Recovery service/Guzman v. Milpitas Unified School District (2009) 4 Cal. Comp.Cases1084 (Appeals Board en banc) (Almaraz/Guzman) as affirmed by the Court of Appeal in Milpitas Unified School Dist.

v. Workers' Comp. Appeals Bd. (Guzman) (2010) 187 Cal.App.4th 808 [75 Cal. Comp. Cases 8371.)

"Total permanent disability" may also be proven by showing the existence of any of the four conditions described in section l) through *section4662(a)(4),* or "in accordance with the fact" as provided in *section 4662(h)*. (See footnote 2, supra.) Martinez, pg. 8.

The recent Devereux v. SCIF (2018) (SAC ADJ10307426), decision is striking similar to the instant case in that the cognitive impairment was ADDED to the hypertension impairment. There, the WCJ followed the treater's determination that indicated that applicant's cardiac impairment was separate and distinct from the cognitive impairment identified by another doctor. The WCJ concluded that the applicant had sustained a separate and distinct cognitive injury even though it was due to the effects of the treatment for the hypertension. The WCJ applied the addition method to calculate the applicant's disability from both his cognitive and cardiac/hypertension injuries due to the absence of overlap.

In Willie Sanchez v. CDCR, 2015 Wrk. Comp. P.D. 482, WCJ, DeWeese, while ruling on a petition to re-open a prior award determined that the applicant had sustained two separate impairments -- Left Atrial enlargement (LAE) and hypertension -- even though both constituted "heart trouble" under LC 3212.2 heart presumption. The WCJ then proceeded to **add the impairments** caused by the two conditions to the prior award -- even though the AME "avoided providing an opinion whether the impairments should be combined or added for rating purposes". Id at p. 19. Defendant filed for reconsideration contending that the WCJ should have instead used the Combined Value Chart and combined the impairments. The WCAB denied reconsideration, instead adopting the WCJ's conclusion that ADDING the two heart disabilities "more accurately reflects applicant's true level of permanent disability." Id at p. 20.

LAW OFFICES OF
Robert Nava & Bret Graham

Commerce Plaza, Ste. 301
420 N. Montebello Blvd.
Montebello, CA 90640

TEL: (323) 888-1818
FAX: (323) 888-7788

February 25, 2019

RE: [redacted] vs. [redacted]
WCAB No.: [redacted]
DOI: CT [redacted]
Claim No: [redacted]

Dear Dr. [redacted]

You are the PQME in INTERNAL MEDICINE from Panel [redacted] on the matter of [redacted] You have evaluated our client [redacted] for disputed heart and cardiovascular system problems on 06/20/2018 and issued reports dated 07/18/2018 and 01/25/2019.

For reasons unknown, the records of [redacted] treating cardiologist, [redacted] M.D., were not enclosed in the records sent to you. You now will find those enclosed.

Please comment on the echocardiograms of 07/31/2018 and 03/10/2017. You will note they both indicate "mild left ventricle hypertrophy". The more recent also indicates mild enlargement of right ventricle and left atrium along with "Stage I diastolic dysfunction." See pp. 32-33; 41-42. From your exam, his Blood Pressure was Stage 1 Hypertension (152/98) despite antihypertensive medication. Applicant asserts that [redacted] should be placed in Class 3 of Table 4-2 due to the LVH alone. Please advise exactly where in Class 3 you place him considering the additional abnormal testing results.

You previously reviewed his emergency Left heart catheterization and coronary angioplasty with stent placement in the right coronary artery on 02/09/2017 following what was diagnose as "acute coronary syndrome". Pages 45-47. Although his ejection Fraction at that time was 35-40%, it appears to have improved to normal range of 62% per the 07/31/2018 echocardiogram. In a treadmill stress test of 12/05/2017, he was able to achieve 13.7 METS and >90% predicted heart rate, so it would appear that he has improved with regard to his coronary heart disease with the procedure of 02/09/2017. Applicant asserts that he nevertheless is best placed in Class 2 of Table 3-6a (as Class 1 is ruled out since he DID have coronary heart disease necessitating the angioplasty to repair the "100% right coronary artery occlusion"). Please advise where exactly in Class 2 he should be placed, given his clinical history and the permanent stents in his right coronary artery.

Additionally, you have noted that he is on the "blood thinner" Brilinta. You have advised that this is necessitated by the coronary heart disease and stent placement. [redacted] has had significant symptoms from that medication including frequent nose-bleeds – one of which you observed. The AMA Guides, 5th, Section 9.6c at page 207 provides for a 10% impairment in this situation with similar medications:

> Long-term anticoagulation with warfarin or low-molecular-weight heparin increases bleeding risk and constitutes impairment in the 10% range

AMA Guides, 5th, page 207. Please advise if you agree with this impairment – especially given that Mr. Luna is symptomatic.

Finally, as you have found applicant MMI/P&S, please provide the most accurate impairment rating per the AMA Guides, 5th edition. If you believe that a generic interpretation of the AMA Guides, 5th does not accurately capture the loss of function or impact on activities of daily living, please explain and use any method, page, chapter or figure in the AMA Guides, 5th that most accurately describes applicant's impairment. Please consider the Almaraz/Guzman and Cannon cases in this regard.

As you have found multiple body parts/systems to have been injured, please consider the Kite decision (wherein the left and right hip impairments were ADDED as opposed to combined with the Combined Values Chart due to their "synergistic" impact on the injured workers' activities of daily living.). Applicant contends that the impairments you have found herein to Coronary Heart Disease and Hypertensive Cardiovascular Diseased should be ADDED since it is the most logical, reasonable and, based on the facts, most accurately reflects the true level of disability sustained by the applicant given these serious cardiovascular diagnoses. This "additive approach" also is endorsed by the AMA Guides, 5th at page 10, paragraph 1:

> "A scientific formula has not been established to indicate the best way to combine multiple impairments. Given the diversity of impairments and great variability inherent in combining multiple impairments, it is difficult to establish a formula that accounts for all situations. A combination of some impairments could decrease overall functioning **more than suggested by just adding** the impairment ratings for the separate impairments.. . . ."

AMA Guides, 5th, page 10 (emphasis added).

In this regard, please advise if (1) the Coronary Heart Disease overlaps with the Hypertensive Cardiovascular Disease; (2) whether they are separate conditions; or (3) whether they in fact have a "synergistic effect" such that [redacted] is at a geometrically greater risk of heart attack, stroke, co-morbidity, death or other serious cardiovascular event due to the combination of the conditions than if he had only just one of them.

Thank you for your assistance with this matter. Should you have any comments or questions please do not hesitate to contact the parties.

Sincerely,

Bret Graham

BG/sc
Enclosure (subpoenaed records [redacted] M.D.)
CC :

2017 Cal. Wrk. Comp. P.D. LEXIS 492

Workers' Compensation Appeals Board (Board Panel Decision)

Opinion Filed October 23, 2017

W.C.A.B. No. ADJ8552281—WCAB Panel: Commissioners Sweeney, Brass, Lowe (dissenting)

Reporter
2017 Cal. Wrk. Comp. P.D. LEXIS 492 *

Silvia Martinez, Applicant v. Pack Fresh Processors, LLC, Midwest Insurance Company, Defendants

Status:

CAUTION: This decision has not been designated a "significant panel decision" by the Workers' Compensation Appeals Board. Practitioners should proceed with caution when citing to this panel decision and should also verify the subsequent history of the decision, as these decisions are subject to appeal. WCAB panel decisions are citeable authority, particularly on issues of contemporaneous administrative construction of statutory language [see *Griffith v. WCAB (1989) 209 Cal. App. 3d 1260, 1264, fn. 2, 54 Cal. Comp. Cases 145]*. However, WCAB panel decisions are not binding precedent, as are en banc decisions, on all other Appeals Board panels and workers' compensation judges [see *Gee v. Workers' Comp. Appeals Bd. (2002) 96 Cal. App. 4th 1418, 1425 fn. 6, 67 Cal. Comp. Cases 236]*. While WCAB panel decisions are not binding, the WCAB will consider these decisions to the extent that it finds their reasoning persuasive [see *Guitron v. Santa Fe Extruders (2011) 76 Cal. Comp. Cases 228, fn. 7 (Appeals Board En Banc Opinion)]*. LexisNexis editorial consultants have deemed this panel decision noteworthy because it does one or more of the following: (1) Establishes a new rule of law, applies an existing rule to a set of facts significantly different from those stated in other decisions, or modifies, or criticizes with reasons given, an existing rule; (2) Resolves or creates an apparent conflict in the law; (3) Involves a legal issue of continuing public interest; (4) Makes a significant contribution to legal literature by reviewing either the development of workers' compensation law or the legislative, regulatory, or judicial history of a constitution, statute, regulation, or other written law; and/or (5) Makes a contribution to the body of law available to attorneys, claims personnel, judges, the Board, and others seeking to understand the workers' compensation law of California.

Disposition: [*1]

Reconsideration is *granted*, and the December 8, 2016 Findings And Award is *affirmed*, except that Paragraph (B) of the Award is *rescinded*, and a new Award is *substituted*. The case is *returned* to the trial level.

Core Terms

permanent disability, disability, impairment, psychiatric, pain, orthopedic, skill, syndrome, workers' compensation, occupation, overlap, earning capacity, upper extremity, vocational, permanent, diagnose,

rebut, panel decision, deposition, kite, diminish, jobs, disability rating, medical evidence, agricultural, rehabilitate, temporary, regional, reconsider, depression

Headnotes

HEADNOTES

Permanent Disability-Rating-Combining Multiple Disabilities-WCAB, in split panel opinion, affirmed WCJ's finding that applicant's 6/30/2011 industrial injuries to her psyche and right upper extremity/chronic regional pain syndrome (CRPS) caused permanent total disability based on scheduled rating under *Labor Code § 4660*, and concluded that WCJ properly determined extent of applicant's permanent disability by adding her psychiatric permanent disability to permanent disability caused by her upper extremity injury and CRPS, rather than combining her disabilities using Combined Values Chart (CVC), when WCAB reasoned that Permanent Disability Rating Schedule (PDRS) is only guide and that adding permanent disabilities caused by injury to separate body parts is proper to determine overall level of permanent disability where addition results in more accurate rating than using CVC to combine disabilities, and that here adding impairments was more accurate because applicant's [*2] orthopedic/CRPS impairment precluded her from performing physical work she had previously done and her psychiatric impairment limited her ability to enter new occupation, and there was no evidence that impairment to different regions of applicant's body overlapped so as to support use of CVC; Commissioner Lowe, dissenting, disagreed with panel majority's finding that record in this case supported deviation from use of CVC by adding orthopedic and psychiatric permanent disabilities, when Commissioner Lowe found no medical evidence indicating that adding disabilities would provide more accurate permanent disability rating than combining disabilities using CVC, and noted that in absence of substantial medical evidence or other evidence supporting use of additive method, PDRS provides for use of CVC to obtain accurate rating of combined effect of orthopedic and psychiatric disabilities, and that if disabilities are simply added together without supporting medical evidence instead of combined using CVC, resulting award of permanent disability indemnity would exceed amount employer is legally obligated to pay. ***PUBLISHER'S NOTE: SEE LEXISNEXIS COMMENTARY ABOUT THIS BOARD PANEL DECISION [*3] AT THE END OF THIS ONLINE DOCUMENT.*** [See generally *Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.02[3], [4][a], 32.03*A; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.11, 7.12; The Lawyer's Guide to the AMA *Guides* and California Workers' Compensation, Ch. 6.]

Permanent Disability-Rating-Permanent Total Disability-WCAB, in split panel opinion, affirmed WCJ's finding that applicant's 6/30/2011 industrial injuries to her psyche and right upper extremity/chronic regional pain syndrome caused permanent total disability "in accordance with the fact" under *Labor Code § 4662(b)*, based on reporting of panel qualified medical evaluator Mark Howard, M.D., which WCAB found was substantial evidence, and on opinion of applicant's vocational expert, Tom Linvill, who provided analysis of individualized factors identified in *Argonaut Insurance Co. v. I.A.C. (Montana) (1962) 57 Cal. 2d 589, 21 Cal. Rptr. 545, 371 P.2d 281, 27 Cal. Comp. Cases 130*, which showed that before her injury applicant was well qualified for agricultural work she was performing but that effects of her industrial injury limited her ability to continue such work, and her limited skills and lower [*4] academic achievement impacted degree she could participate in labor market, and WCAB panel majority, while recognizing that decisions

in *Ogilvie v. W.C.A.B. (2011) 197 Cal. App. 4th 1262, 129 Cal. Rptr. 3d 704, 76 Cal. Comp. Cases 624*, and Contra *Costa County v. W.C.A.B. (Dahl) (2015) 240 Cal. App. 4th 746, 193 Cal Rptr. 3d 7, 80 Cal. Comp. Cases 1119*, appear to reject consideration of nonindustrial individualized factors described in *Montana* as way of rebutting diminished future earning capacity factor in Permanent Disability Rating Schedule, determined that these individualized factors are relevant in evaluating injured worker's amenability to vocational rehabilitation as discussed in *Dahl*, and that Mr. Linvill properly considered them in determining that applicant could not participate in open labor market; Commissioner Lowe, dissenting, opined that there was insufficient evidence to support finding of permanent disability under *Labor Code § 4662(b)*, and that applicant's permanent disability should have been determined pursuant to *Labor Code § 4660*, when Commissioner Lowe reasoned that reporting of Mr. Linvill was not sufficient to rebut scheduled rating under *Ogilvie*, because [*5] he acknowledged that applicant's inability to find alternative work was due to nonindustrial factors, including lack of academic skill and lack of fluency in English, and that under *Ogilvie* evidence that injured worker's loss of future earning capacity was caused by nonindustrial factors, such as general economic conditions, illiteracy, English proficiency, or lack of education, cannot rebut scheduled permanent disability rating. [See generally *Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.02[3], [4], 32.02[2], 32.03*A; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.11, 7.12; The Lawyer's Guide to the AMA *Guides* and California Workers' Compensation, Chs. 3, 4, 5, 8, 10.]

Counsel

For applicant—Rucka, O'Boyle, Lombardo & McKenna

For defendants—Bradford & Barthel

Opinion By: Commissioner Marguerite Sweeney

Opinion

OPINION AND DECISION AFTER RECONSIDERATION

Defendant's petition for reconsideration of the December 18, 2016 Findings And Award of the workers' compensation administrative law judge (WCJ) was earlier granted in order to further study the record and issues in the case. The WCJ found in pertinent part that applicant incurred a period of temporary disability, total permanent disability **[*6]** and need for future medical treatment as a result of the industrial injury to her right upper extremity and psyche sustained while employed by defendant as a packer on or about June 30, 2011.

The WCJ explains in his December 18, 2016 Opinion On Decision (Opinion) that he reached his decision by adding the percentage of permanent disability caused by the injury to the right upper extremity and consequential complex regional pain syndrome (CRPS) to the percentage of permanent disability caused by the injury to applicant's psyche to calculate the overall permanent disability caused by the industrial injury instead of using the Combined Values Chart (CVC) in the 2005 Permanent Disability Rating

Schedule (PDRS) to combine those percentages. [1] The WCJ further determined that the finding of total permanent disability is "in accordance with the fact" as provided in Labor Code section 4662(b).

Defendant contends in its Petition For Reconsideration (Petition) that the CVC should be used **[*7]** to determine applicant's overall permanent disability instead of adding the disabilities caused by the orthopedic/CRPS injury and injury to psyche, that the finding of total permanent disability is not "in accordance with the fact" as described in Labor Code section 4662(b) and is not otherwise supported by substantial evidence, that it should be relieved of its stipulation to the occupational variant of 490, that the award of temporary disability indemnity exceeds the amount allowed by Labor Code section 4656(c)(2), and that the record should be opened to allow defendant to offer into evidence a medical report that was not available at trial. [2]

An answer was received from applicant.

The WCJ provided a Report And Recommendation On Petition For Reconsideration (Report) recommending that the award of temporary disability indemnity be amended to include the limitation contained in section 4656(c)(2), but that his decision otherwise be affirmed.

As the Decision After Reconsideration of the Workers' Compensation Appeals Board, the award of temporary disability indemnity is amended to add the 104 compensable weeks limitation on temporary disability indemnity contained in section 4656(c)(2), but the decision of the WCJ is otherwise affirmed for the reasons below. The permanent disability caused by the injury to applicant's psyche and her CRPS combine to preclude her from engaging in gainful employment and constitute total permanent disability in accordance with the fact.

BACKGROUND

The WCJ describes the procedural and factual background of the case in **[*9]** his Report, as follows:

> Applicant, Silvia Martinez, while employed on or about 6/30/11, sustained an admitted injury to her right upper extremity and psyche arising out of and occurring in the course of her employment (AOE/COE). Applicant was initially treated conservatively ultimately undergoing an MRI which disclosed an oblique tear of the TFCC, a partial tear of ulnar attachment and a likely tear of the volar radial ulnar ligament. On 4/12/12, she underwent arthroscopic surgery with Dr. Rasi with no meaningful improvement. On 12/3/12, she was then seen in consultation with Dr. Christian Foglar, M.D.[,] who after evaluation recommended injection of the site. Initially, following the injections there was some improvement. On 6/4/13, she underwent a second surgery performed by Dr. Christian

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[1] Applicant's condition is diversely described in the record as "complex regional pain syndrome," "CRPS," "reflex sympathetic syndrome," "reflex sympathetic dystrophy," "RSD," and "chronic reflex pain syndrome."

[2] Further statutory references are to the Labor Code.

Section 4662 subdivisions (a)(1) through (a)(4) provide for a finding of "total permanent disability" when any of the following conditions exist: (1)Loss of both eyes or the sight thereof. (2) Loss of both hands or the use thereof. (3) An injury resulting in a practically total paralysis. (4) An injury to the brain resulting in permanent mental incapacity." Section 4662 subdivision (b) provides as follows: "In all other cases, permanent total disability shall be determined in accordance with **[*8]** the fact."

Section 4656(c)(2) provides as follows: "Aggregate [temporary] disability payments for a single injury occurring on or after January 1, 2008, causing temporary disability shall not extend for more than 104 compensable weeks within a period of five years from the date of injury."

Foglar. He reported that she returned with much less pain and swelling. Applicant had worked in a modified duty status from July 1 through December of 2011. Eventually, the employer moved to a different location and she was unable to continue working. Up until this time she had worked since the age of 17 through 2011 as a field worker and packer in agricultural work.

Following her second surgery, **[*10]** it is noted that Dr. Foglar in his treatment note of 12/20/13 at page 12 states: '[s]he clearly has severe reflex sympathetic dystrophy. ['] He noted that the 'hand is swollen, cold and extremely stiff. She can't move it much. By all means a useless and severely altered hand.' He concludes it is a chronic reflex pain syndrome. Applicant has continued to treat with conservative care by Dr. Melinda Brown who also diagnosed reflex sympathetic dystrophy. Dr. Lisa Kroopf, M.D. examined the applicant on 6/10/16 (Exhibit A-1) and notes again a diagnosis of complex regional pain syndrome. A panel QME [Panel Qualified Medical Evaluator or PQME], Dr. Mark Howard, evaluated the patient and in his final evaluation concluded applicant has complex regional pain syndrome. On cross-examination by the defendant, he did not waiver from his opinion stating that he had treated patients with this condition and felt qualified to make that determination.

At trial, Applicant presented with a right dominant hand that was swollen the size of a grapefruit and fingers swollen like stiff sausages, applicant indicated it was very sensitive to touch and cause severe pain. Dr. Kroopf noted in her treatment records **[*11]** (Exhibit A-1): '[S]he has a bit more pain today because her daughter accidentally bumped her hand and this type of minimal trauma sets off a severe pain cascade.'

Applicant was also evaluated by Dr. Mark Kimmel, Ph.D., a [PQME] in psychology, (Exhibit A-6). He noted in the history [that] Dr. James Weiss, M.D., a psychiatrist, diagnosed her with major depression and a chronic medical condition noted passive suicidal ideation; noted that her pain levels were 6–7/10. He does reference [a November 22, 2013 report by Dr. Tong that 'I think it is time to think about Reflex Sympathetic Syndrome.']. In Dr. Kimmel's report of 5/25/15, he makes note that she did make a suicide attempt in October 2014. Dr. Kimmel concluded in his report of 12/15/15 that applicant suffers from a major depressive disorder; that she has a GAF score of 55 - that she has moderate impairment with regard to activities of daily living. She has reclusive symptoms. She has a moderate impairment in her range of concentration, persistence, and pace. That she has a significant concern about re-injuring her hand. Dr. David Torrez, Ph.D. (Exhibit A-9) in his report of 3/26/15 concluded and confirmed a diagnosis of severe depression. **[*12]** In Exhibit A-14 the treating physician notes that the complex regional pain syndrome symptomatology is still severe and that because of the symptoms the injured worker 'keeps the hand covered to avoid contacts or brushes on it; she can't grasp'.

The applicant's Vocational Evaluator, Mr. Linvill, in his report of 10/19/14 (Exhibit A-5) makes note of applicant's work and educational background. She has 9 years of education and with reasonable reading and writing skills in Spanish—he notes that she reads books and magazines in Spanish. She has worked for 12 years as a field worker; and she had taken some English classes but stopped as it interfered with work. She is monolingual Spanish; probably understands some English.

It should be noted that applicant's educational and language skills are commensurate with similarly situated workers. Exhibit W-1 notes that most of the agricultural workers (97%) completed their highest grade in their country of origin. That most of the foreign-born workers had completed their sixth grade. With respect to language skills, Spanish was the predominant native language for the crop workers (81%). Forty-four (44%) percent reported they could not speak English **[*13]** at all; 53%

cannot read English at all. Table 3.1 shows that of the Mexican born agricultural worker, 68% did not speak English at all and just 24% speak it a little.

The applicant's skills, as reported by Mr. Linvill, her academics skills were poor; as she had done only unskilled work. But it should be noted that her history of work showed that she was effective in production prior to her injury; that she had no problems with attendance or punctuality. With respect to the single arm occupations, he notes that there are not many in this number and also notes that her *pain syndrome would impact her ability to handle these jobs*. As he reports, the jobs available to her would have include greeter, gate guard, and limited service cashiering positions. Most of these positions require 'interpersonal interaction' and do not focus upon production activity. The primary activities in these jobs are social, not hand oriented. The difficulty in this case with Ms. Martinez is the pain that she suffers; difficulty with engaging with people and socializing. Mr. [Linvill's] report took into account all of the impairments the applicant has suffered from this injury.

Applicant was also examined by a Vocational **[*14]** Evaluator selected by the defendant, Ms. Emily Tincher, (Exhibit D-6)[. I]n her report of 6/8/15 she did little to rebut Mr. Linvill's findings; she simply concluded that because of the GAF score she could not take into consideration the severe major depression which this woman suffers, in determining whether she could maintain a work position saying that the GAF psychiatric ratings are not tenable for determining employment outcomes. She did not consider the doctor's discussion of applicant's impairments. Additionally, she did not take into consideration the pain syndrome which would affect the applicant's ability to use her damaged hand as an assist for her left hand. While she indicates that the applicant's language and educational limitations may affect her rehabilitation she does not identify the kinds of work that would be available to her if she were retrained. Nor does she take into account the pain syndrome and major depression that applicant suffers from this injury and whether [there is] any job [for a] person with a useless right dominant upper extremity, a severe pain syndrome and a major depression.

The matter came before us at hearing. Following receipt of testimony from **[*15]** the applicant and observation of the applicant's hand, which was quite swollen appearing the size of a grapefruit and with thick sausage-like fingers, it was concluded that applicant was permanently and totally disabled. As part of the gathering of evidence, a rating was obtained from the Rater[.] At trial the parties had stipulated to 490 as the occupational group. This WCJ was concerned about this stipulation so when he requested the rating, he asked the rater to rate it under 491 as well as 490 because of the possible mistake. But at the time of the cross-examination of the Rater, there was no effort made by either party to withdraw from that stipulation. It is a policy of the Board to encourage parties to stipulate to facts, if we will not ignore those stipulations. Certainly, had a party inadvertently stipulated to the 490 occupational group, they would have presented that to the Judge at the time of the trial and/or at the time of the cross-examination of the Rater; but that did not occur. So, in deference to the parties' stipulation, it was applied to the rating. Because the psychiatric disability and the orthopedic/neurological disability effect different regions of the body **[*16]** and impact different activities the CVC was not used and it was concluded the disability was best described by adding the disabilities rather than combining them using the CVC. (Italics in original.)

The WCJ explains in his Report that he found that applicant is totally permanently disabled because the vocational reporting identified no occupations "that could accommodate this worker with a useless dominant limb, a severe pain syndrome and a major depression," and "[t]here is no evidence that the

applicant with these impairments would be amendable to rehabilitation even if her educational level was higher or her English skills were better."

In addition, the WCJ determined that the impairment resulting from applicant's orthopedic injury and CRPS does not overlap the impairment caused by her psychiatric injury, and that adding the ratings for those separate areas of the body shows that applicant is totally permanent disability, writing in his Report as follows:

> Th[e] determination [of permanent disability] cannot be made based upon the whole person impairment percentage alone. The physicians, as they did in this case, must spell out the effect of the impairment on the applicant's work life. **[*17]** Here, the orthopedic impairment affects the use of the right dominant hand finding it effectively useless to the applicant at work. Likewise, the psychiatrics impairments **and** the associated pain syndrome affect her ability to do the occupations available to similarly situated workers who have lost the use of their upper extremity, i.e. a social engagement type of occupation. It is not usual for an orthopedic surgeon to determine the functional limitations from a psychiatric injury nor is it usual for a psychologist to determine the functional limitations for an orthopedic disability. Thus, they are not able to determine if the limitations overlap or not. However, it is usual for the Board to determine if functional impairments overlap or are added on to other functional impairments. Based on the facts of this case it was determined that the functional impairments were best added rather than combined. (Bolding in original.)

DISCUSSION

For injuries occurring before January 1, 2013, like the June 30, 2011 injury in this case, section 4660 provides for use of the 2005 Permanent Disability Rating Schedule (PDRS) to determine the level of permanent disability. As part of that process, a physician **[*18]** may, with proper explanation, deviate from the percentages contained in the applicable chapter of the American Medical Association's Guides to the Evaluation of Permanent Impairment, Fifth Edition (AMA Guides) in order to better express the injured worker's level of impairment in light of the physician's skill, knowledge, and experience, as well as considerations unique to the injury and information derived from extrinsic resources. (*Almaraz v. Environmental Recovery Service/Guzman v. Milpitas Unified School District (2009) 74 Cal.Comp.Cases 1084 (Appeals Board en banc)* (*Almaraz/Guzman*) as affirmed by the Court of Appeal in *Milpitas Unified School Dist. v. Workers' Comp. Appeals Bd. (Guzman) (2010) 187 Cal.App.4th 808 [75 Cal.Comp.Cases 837]*.)

"Total permanent disability" may also be proven by showing the existence of any of the four conditions described in section 4662(a)(1) through section 4662(a)(4), or "in accordance with the fact" as provided in section 4662(b). (See footnote 2, *supra*.)

In addition, it has been held that an injured worker may present evidence that rebuts a PDRS rating and supports a finding of a higher level of permanent disability. (*Ogilvie v. Workers' Comp. Appeals Bd. (2011) 197 Cal.App.4th 1262 [76 Cal.Comp.Cases 624]* **[*19]** (*Ogilvie*); *Contra Costa County v. Workers' Comp. Appeals Bd. (Dahl) (2015) 240 Cal.App.4th 746 [80 Cal.Comp.Cases 119]* (*Dahl*).)

Three ways of rebutting the PDRS rating are described in *Ogilvie*.

The first is by showing factual error in the calculation of a factor in the rating formula or in the application of the formula. (*Ogilvie, supra, 197 Cal.App.4th at p. 1273*.)

The second is by showing the omission of medical complications aggravating the employee's disability in the preparation of the rating schedule. (Ogilvie, supra, 197 Cal.App.4th at p. 1276 "in certain rare cases [in which] the amalgamation of data used to arrive at a diminished future earning capacity may not capture the severity or all of the medical complications of an employee's work-related injury" and "a claimant can demonstrate that the nature or severity of the claimant's injury is not captured within the sampling of disabled workers that was used to compute the adjustment factor".)

The third method identified in *Ogilvie* of rebutting a scheduled rating is by showing that the employee is not amenable to rehabilitation and suffers a greater loss of future earning capacity than reflected in the scheduled rating. (Ogilvie, supra, 197 Cal.App.4th at p. 1274–1275, **[*20]** citing LeBoeuf v. Workers' Comp. Appeals Bd. (1983) 34 Cal.3d 234 [48 Cal.Comp.Cases 587] (*LeBoeuf*) ["An employee effectively rebuts the scheduled rating when the employee will have a greater loss of future earnings than reflected in a rating because, due to the industrial injury, the employee is not amenable to rehabilitation...the most widely accepted view of [the holding in *LeBoeuf*,] and that which appears to be most frequently applied by the WCAB, is to limit its application to cases where the employee's diminished future earnings are directly attributable to the employee's work-related injury, and not due to nonindustrial factors such as general economic conditions, illiteracy, proficiency in speaking English, or an employee's lack of education".)

In this case, the WCJ determined that the scheduled rating under section 4660 supports a finding of total permanent disability when the permanent disability caused by the upper extremity injury and CRPS is added to the permanent disability caused by the psychiatric injury, as explained by the WCJ in his Opinion as follows:

> If **[*21]** we rate the psyche using a GAP of 55, it rates as follows allowing for the 10% apportionment: we have 90% (14.01.00.00–23[8] 32–490J -44–40) 36. For the right upper extremity which suffers from complex regional pain syndrome, a chronic condition: we have a 51% WPI which is rated as follows: (13.11.01.03–51 [5] 65–490I -73–70) - adding those two together results in a 106% which is a 100% permanent and total disability.

Defendant contends in the Petition that it was error for the WCJ to add the levels of permanent disability caused by the CRPS and psychiatric injury to determine total permanent disability because that approach is not endorsed by the medical reporting and because there is overlap between the two conditions that supports use of the CVC. [3] In support of that contention, defendant cites five earlier Appeals Board panel decisions. However, in four of those decisions the panels concluded that adding the permanent disabilities provided a more accurate reflection of the injured worker's actual level of permanent disability than using the CVC. (Athens Administrators v. Workers' Comp. Appeals Bd. (Kite) (2013) 78 Cal.Comp.Cases 213 [2013 Cal. Wrk. Comp. LEXIS 34] [appropriate to **[*22]** use additive approach because AMA Guides describe several methods of combining impairments and rigid application of CVC is not mandated]; Los Angeles County Metropolitan Transportation Authority v. Workers' Comp. Appeals Bd. (La Count) (2015) 80 Cal.Comp.Cases 470 [2015 Cal. Wrk. Comp. LEXIS 47] [proper to add impairments rather than use CVC in light of AME opinion that there was synergistic effect to orthopedic injuries so that they should be added rather than combined]; *Diaz v. State* (November 18, 2015, ADJ7682048) [2015 Cal. Wrk. Comp. P.D. LEXIS 683] [additive approach within the authority of WCJ because there was no clear overlap in impairments]; *Sanchez v. California Dept., of Corrections* (August 4, 2015, ADJ6995506) [2015 Cal.

[3] Using the CVC to combine a 36% rating with a 70% rating yields a combined rating of 81%.

Wrk. Comp. P.D. LEXIS 482] [additive rating may be used when combining multiple impairments results in more accurate rating of overall permanent disability]; but see, Barela v. State of California (May 13, 2014, ADJ7181658) [2014 Cal. Wrk. Comp. P.D. LEXIS 217] [adding permanent disability caused by separate impairments not shown to provide more accurate measure of worker's overall level of permanent disability in absence of supporting opinion of agreed **[*23]** medical examiner and WCJ reasoning].)

Moreover, it has long been recognized that a rating schedule like the PDRS is only a guide and adding the level of permanent disability caused by an injury to separate body parts is proper to determine the overall level of permanent disability when that results in a more accurate rating than using the CVC to combine them. (Mihesuah v. Workers' Comp. Appeals Bd. (1976) 55 Cal.App.3d 720, 728 [41 Cal.Comp.Cases 81] [schedule "is only a 'guide' to be employed" and that the final rating should reflect "the entire picture of disability and possibility of employability"]; Abril v. Workers' Comp. Appeals Bd. (1976) 55 Cal.App.3d 480 [40 Cal.Comp.Cases 804] [work restriction must be considered in evaluating employee's permanent disability based upon diminished ability to compete on the open labor market even if not covered in schedule]; County of Los Angeles v. Workers' Comp. Appeals Bd. (LeCornu) (2009) 74 Cal.Comp.Cases 645 (writ den.) [finding of total permanent disability affirmed notwithstanding that recommended combined schedule rating was 96% because AME opined **[*24]** that applicant was unable to return to the open labor market]; Morgan v. Workers' Comp. Appeals Bd. (1983) 48 Cal.Comp.Cases 98 (writ denied) [table for combing permanent disabilities only a guide and finding of 76% permanent disability correct even though application of the table would result in 96% rating]; State of California v. Workers' Comp. Appeals Bd. (McDonald) (1982) 47 Cal.Comp.Cases 1204 (writ den.) [finding of total permanent disability proper based upon evidence that applicant unable to work notwithstanding that schedule and table combining disabilities yielded 97 1/2% rating].)

Here, the WCJ determined that applicant's functional impairments were best added rather than combined because her orthopedic/CRPS impairment precludes her from performing the physical work she has done in the past and her psychiatric impairment limits her ability to enter a new occupation, described on page 7 of the Report as "a social engagement type of occupation." The WCJ found that the orthopedic/CRPS and psychiatric impairments involve different regions of the body and that there is no evidence that the impairments overlap. As noted by the WCJ in his Report, adding the CRPS and psychiatric **[*25]** limitations is consistent with the fact that the orthopedic PQME did not determine functional limitations flowing from a psychiatric injury and the psychiatric PQME did not determine the functional limitations caused by orthopedic injury. In that the WCJ found that the injuries did not overlap in a way that supports use of the CVC, he determined that it was more accurate to add the functional impairments rather than combine them to describe applicant's overall level of permanent disability.

Defendant disputes the WCJ's determination, and argues that his analysis is "completely one-sided" and "overly simplistic." (Petition, 7:14–18.) In defendant's view, a person with psychiatric impairment and pain "may be emotionally reluctant to utilize that extremity due to a fear of pain, and this constitutes "overlap at least to some degree" that supports use of the CVC. (*Id*, 7:23–8:14.)

Defendant cites no medical evidence in support of its argument that there is overlap between applicant's orthopedic/CRPS disability and her psychiatric disability that requires use of the CVC. Instead, a review of the medical reporting reveals that the two disabilities impact applicant's ability to return to work **[*26]** in different ways. As the WCJ discusses in his Opinion and Report, the orthopedic/CRPS disability precludes applicant from returning to the agricultural work that she has successfully performed her entire life. The psychiatric disability affects applicant's amenability to vocational rehabilitation that would allow

her to work in jobs outside the agricultural sector that do not demand the physical capability of her past employments.

It has been recognized that a disability rating, "should reflect as accurately as possible an injured employee's diminished ability to compete in the open labor market." (*LeBoeuf, supra*, 34 Cal.3d at pps. 245–246.) In this case, the WCJ reasonably concluded that adding the orthopedic/CRPS and psychiatric permanent disabilities more accurately reflects applicant's *entire* permanent disability and is a more accurate measure of applicant's diminished future earning capacity than results from using the CVC.

In addition to finding total permanent disability by adding the orthopedic/CRPS and psychiatric permanent disabilities, the WCJ also found total permanent disability "in accordance with the fact" under section 4662(b), **[*27]** and that finding is supported by the record.

Defendant challenges the WCJ's finding of total permanent disability under section 4662(b) by arguing that the PQME, Dr. Howard, is not an expert on CRPS and that his reporting "does not satisfy requirements for diagnosis of CRPS as set forth in the AMA Guides, 5th Addition." (Petition, 8:25–26.) Defendant also argues that a November 9, 2016 report by Dr. Howard that defendant received after the mandatory settlement conference should now be received into evidence because it includes observations that are inconsistent with the earlier diagnosis of CRPS provided by the physician. These contentions fail because Dr. Howard is a qualified physician whose diagnosis of CRPS is supported by the record.

In his August 6, 2014 deposition (Defendant's Exhibit D-3, "Deposition"), [4] Dr. Howard acknowledged that he is not an "expert" on CRPS. (Deposition, 6:2–8; 9:21–10:2.) However, he also testified that he has diagnosed CRPS before, and his diagnosis in this case provides a "physiologic or anatomic explanation for [applicant's] remarkable dysfunction after what would be considered two relatively minor surgeries." (Deposition, 8:25–9:1.)

When asked during his deposition about how he made the diagnosis of CRPS, Dr. Howard responded as follows:

> A. [S]he was a pretty classic presentation of CRPS. If according to AMA [G]uides they absolutely have to have eight of those to make the diagnosis, you can certainly make the argument that she doesn't meet that criterion, doesn't carry that diagnosis. But, in my opinion, she does.... (Deposition, 11:23–12:11–16)
>
> [S]he functionally really almost had a—what we euphemistically call a hook hand, being that it's really quite nonfunctional. And you're—it almost functions more as a hook by virtue of weakness, dysesthetic pain, and stiffness.
>
> So I describe as best I can her stiffness and her lack of motion. And I go through the different joints. And you can see that analysis and sensory testing. I reported it as definitely altered inhibitus throughout all five digits ... (Deposition, 13:4–13)

Defendant argues in its Petition that Dr. Howard's reporting is not substantial evidence because he admits he is not an expert on CRPS and his testimony is "unabashedly non-expert." (Petition, 11:6.) This argument is without merit. **[*29]** Defendant confuses an individual's expertise in dealing with a particular medical condition with a physician's overall qualifications to provide opinion as a medical expert. Dr.

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[4] The deposition **[*28]** date is incorrectly identified in the Minutes of Hearing as August 8, 2014.

Howard has substantial experience as a physician and surgeon, and he has diagnosed CRPS on prior occasions, as he explained in his deposition. He expressed no reservation in his diagnosis of CRPS or its effects. (Deposition, 15:11–19 ("Q. Was there anything said today that would change your opinion with respect to the 51 percent whole person impairment rating related to the CRPS I diagnosis? A. Short answer, no...".)

Dr. Howard's qualifications meet the criteria for providing expert opinion. (See, Evid. Code, § 800 et seq.; People v. Chapman, 207 Cal.App.2d 557, 576 [the determination of an expert's qualification is primarily the function of a trial court, and its ruling will not be disturbed in the absence of an abuse of discretion].) Here, the WCJ properly recognized Dr. Howard as an expert based upon his knowledge, skill, experience, training and education. (*Id*; People v. Cruz (1968) 260 Cal.App.2d 55.)

Moreover, no medical opinion supports the implication in defendant's argument that applicant does not have **[*30]** CRPS. To the contrary, the overwhelming weight of the evidence supports Dr. Howard's diagnosis of CRPS, including the reporting of applicant's treating physician Dr. Tong who also diagnosed and the WCJ's observation of applicant's arm and hand as set forth in the Report as quoted above. The diagnosis of CRPS is not changed by the November 9, 2016 surgical consultation report prepared by Dr. Howard after the July 26, 2016 trial, and there is no good cause to open the record and receive that report into evidence at this time. (Cal. Code Regs., tit. 8, § 10856(d) [a factor in deciding whether to receive newly discovered evidence is "the effect the evidence will have on the record and on the prior decision"].)

In addition to challenging the substantiality of the medical reporting by Dr. Howard, defendant contends that the alternative basis for the WCJ's finding of total permanent disability "in accordance with the fact" under section 4662(b) is not supported by the reporting of applicant's vocational expert, Tom Linvill, because he had an "erroneous" understanding of the "impairment analysis" provided by Dr. Howard. (Petition 15:27–16:9.) Defendant disingenuously argues that Mr. Linvill **[*31]** relies upon "an erroneous set of key facts" because he describes applicant's reduction in function as "severe" based upon Dr. Howard's October 19, 2014 report of an "80% upper extremity deficit," and that "[o]bviously an impairment of 80% is vastly more than an impairment of 51%." (*Id.*)

In fact, an "85% upper extremity impairment...equals 51% whole person impairment," as Dr. Howard wrote in his February 20, 2014 report, where he noted that the 85% upper extremity impairment he calculated was based upon table 16.3, page 439 of the AMA Guides, and that the upper extremity impairment is all attributable to "postoperative CRPS I (RSD)." (Defendant's Exhibit D-1.) Mr. Linvill did not rely upon an erroneous set of key facts as asserted by defendant. To the contrary, he correctly described applicant's 85% upper extremity impairment as severe, consistent with the opinion of Dr. Howard and the WCJ's observations of applicant's condition.

Defendant also notes that Mr. Linvill wrote in his reporting that applicant's "limited skills" and "lower academic achievement" impact her participation in the labor market, but that this could change over sufficient time if she improved her academic skill in Spanish **[*32]** and fluency in English. From that observation, defendant asserts that Mr. Linvill's reporting "would have the employer compensate applicant for impairing factor not directly caused by the injury" and is inconsistent with the view of the Court in *Dahl*. (Petition 13:21–22.)

What defendant overlooks in its argument is that applicant worked successfully for many years for defendant and others with her current language skills and academic achievement. It is only because of the

industrial injury that applicant is unable to continue employment in her regular occupation. In other words, applicant's loss of earning capacity was caused by the industrial injury, not by her limited academic achievement or lack of fluency in English.

The importance of considering all factors in evaluating loss of future earning capacity was recognized by the Supreme Court in *Argonaut Ins. Co. v. Industrial Acc. Com. (Montana) (1962) 57 Cal.2d 589 [27 Cal.Comp.Cases 130]* (*Montana*), where the Court wrote as follows:

> An estimate of earning capacity is a prediction of what an employee's earnings would have been had he [or she] not been injured...[A] prediction [of earning capacity for purposes of permanent disability] **[*33]** is... complex because the compensation is for loss of earning power over a long span of time...In making a permanent award, [reliance on an injured employee's] earning history alone may be misleading...[A]ll facts relevant and helpful to making the estimate must be considered. The applicant's ability to work, his [or her] age and health, his [or her] willingness and opportunities to work, his [or her] skill and education, the general condition of the labor market, and employment opportunities for persons similarly situated are all relevant. (*Montana, supra, 57 Cal.2d at pp. 594–595 [27 Cal.Comp.Cases at p. 133*], internal citations omitted, bracketed material added.)

It is recognized that *Ogilvie* and *Dahl* includes no citation to or mention of the Supreme Court's decision in *Montana*, and that those decisions appear to reject consideration of the nonindustrial individualized factors described in *Montana* as a way of rebutting the diminished further earning capacity factor in the PDRS. As the Court wrote in *Dahl*:

> [The] vocational expert's method attempted to establish applicant's diminished future earning capacity based not on applicant's individual assets and detriments but on those of theoretical **[*34]** group of 'similarly situated employees,' which expert identified as more similarly situated to applicant than group identified in Schedule for someone with applicant's characteristics, that, under this approach, injured workers would be permitted to rebut their scheduled rating in virtually all cases when expert can provide statistical analysis of group of individuals he or she claims is more similarly situated to applicant than that identified in Schedule, producing greater diminished future earning capacity than that determined by applying Schedule, precisely approach that is no longer permissible...(*Dahl, supra 197 Cal.App.4th at p. 758*.)

It is also recognized that *Ogilvie* considered the enactment of Senate Bill 899 and *section 4664(a)* after the decision in *Montana* as limiting an employer's liability for an injured worker's permanent disability to "the percentage of permanent disability directly caused by the injury," so that a scheduled rating under the PDRS is not now rebutted by "nonindustrial factors such as general economic conditions, illiteracy, proficiency in speaking English, or an employee's lack of education" that limit future earning capacity. (*Ogilvie, supra, 197 Cal.App.4th at 1275*.)

Nevertheless, **[*35]** individualized factors are relevant in evaluating a worker's amenability to vocational rehabilitation, as further addressed by the Court in *Dahl* as follows:

> The first step in any *LeBoeuf* analysis is to determine whether a work-related injury precludes the claimant from taking advantage of vocational rehabilitation and participating in the labor force. This necessarily requires an individualized approach...The focus [is] on the limitations flowing from the claimant's particular condition, not the earning potential of similarly situated individuals who might

be subject to different limitations. It is this individualized assessment of whether industrial factors preclude the employee's rehabilitation that *Ogilvie* approved as a method for rebutting the Schedule. (*Dahl, supra, 240 Cal.App.4th at p. 758.*)

In this case, Mr. Linvill provided an analysis of the individualized factors identified in *Montana* on pages 7 and 8 of his October 19, 2014 report. This analysis shows that before the injury applicant was well qualified for the agricultural work she was performing, and that it is the effects of the industrial injury that limits her ability to continue work in that sector. As Mr. Linvill wrote, **[*36]** "[h]er limited skills and her lower academic achievement certainly impact the degree she can participate in the labor market. Until her injury, they did not prevent effective work."

By contrast, defendant's vocational expert, Ms. Tichner, opines on pages 17 and 18 of her June 8, 2015 report that applicant has sustained *no* loss of future earning capacity as a result of the industrial injury. Ms. Tichner provides her explanation in the Conclusion section of her report on page 24 as follows:

Ms. Martinez is, in fact, unable to benefit from vocational rehabilitation due to the effect of her functional illiteracy and inability to speak fluent English. Were it not for these non-industrial factors, she would be able to access the jobs I selected in the preliminary report. The jobs are low skilled and workers learn the tasks through brief demonstration. No transferable skills are needed. The jobs are suited for 'one-armed' workers.

In fact, Ms. Martinez is not an amputee, and can use her injured arm and hand as a helper hand. She demonstrated her ability to write, and she performs her ADLs such as driving which requires use of two hands. Therefore, I find my suggestions for future jobs to be **[*37]** conservative, and accurate.

The wages for the alternative employment pay, an estimated $ 9.17/hr. in 2014 compared to average wages of a similarly situated worker of $ 9.16/hr., there is Zero DFEC. Zero DFEC would be associated with the FEC modifier of One.

It is not possible to reconcile Ms. Tichner's opinion that applicant incurred *no* loss of future earning capacity because of her injury with the evidence of her condition and circumstances. Applicant has always worked in physical occupations, and has lost effective use of her right, dominant upper extremity, and is now "precluded from any grasping, lifting, carrying, or repetitive motions like keyboard or any requirements requiring, you know, fine motor dexterity." (Deposition 13:24–14:5.) As Ms. Linvill wrote on pages 8 and 11 of his report:

> People who support the agricultural industry require sufficient strength and dexterity to move, sort, pick and package products. Prior to injury, these were the employment opportunities Ms. Martinez sought. She effectively found good employment with Pack Fresh Processors. Now, she must find basic work that allows her to depend on less manipulation, less grasping and less dexterity. This is a major **[*38]** challenge for Ms. Martinez and for others who are similarly situated...
>
> Ms. Martinez worked in types of jobs described as unskilled by the Dictionary of Occupational Titles. In the classic sense, she does not develop transferable skills in those occupations. At the same time, as a long term, consistent worker, she built adaptive skills that would allow her the capability of moving into other work. Her experience is most related to agricultural field work and agricultural processing work. Without her injury, she could have moved into other positions in either of those situations.

JAMES RUCKER

> Now she is a person whose dominant hand does not function. Now she is a person who has pain that is exceptionally problematic. This definitely impacts her earning capacity.

Defendant argues that Mr. Linvill's reporting is entitled to no weight because he is not qualified to provide expert opinion and his reporting is not in a proper form and is likely intentionally incomplete." (Petition, 13:23–14:18.) Defendant's objections to Mr. Linvill's qualifications and the form of the report were not raised at trial and the reporting was received into evidence without objection at that time. (July 26, 2016 Minutes Of Hearing, **[*39]** 4:15–16.) In addition, the bare assertion that Mr. Linvill's reporting is intentionally incomplete is unsupported by any evidence and this contention was also not raised at trial. Failure to raise objections at the hearing where they may first properly be raised acts as a waiver of the objections, and they need not be further addressed. (See, *U.S. Auto Stores v. Workers' Comp. Appeals Bd. (Brenner) (1971) 4 Cal.3d 469* [36 Cal.Comp.Cases) 173; *Los Angeles Unified Sch. Dist. v. Workers' Comp. Appeals Bd. (Henry) (2001) 66 Cal.Comp.Cases 1220* (writ denied).)

Similarly, defendant's request to be relieved of its stipulation to the occupational variant of 490 is not timely raised. Stipulations made at a mandatory settlement conference, like the one the parties made to the occupational variant of 490, are binding upon the assenting parties unless good cause to be relieved of the stipulation is shown. (*Lab. Code, § 5502(d)(2)*; *County of Sacramento v. Workers' Comp. Appeals Bd. (Weatherall) (2000) 77 Cal.App.4th 1114, 1120 [65 Cal.Comp.Cases 1]*; *Huston v. Workers' Comp. Appeals Bd. (1978) 95 Cal.App.3d 856 [44 Cal.Comp.Cases 798]*.) A change in the case law or judicial interpretation of a statute **[*40]** may provide "good cause" to relieve a party from a stipulation, but a unilateral mistake as defendant now claims is not recognized as good cause that supports nullification of an agreement. (*Id*; *State Comp. Ins. Fund v. Industrial Acc. Com. (Dean) (1946) 73 Cal.App.2d 248, 257 [11 Cal.Comp.Cases 30]* (*Dean*); see also, *General Ins. Co. v. Workers' Comp. Appeals Bd. (Sale) (1980) 104 Cal.App.3d 278, 285 [45 Cal.Comp.Cases 403]*; *Brunski v. Industrial Acc. Com. (1928) 203 Cal. 761* [15 I.A.C. 128]; *Smith v. Workers' Comp. Appeals Bd. (1985) 168 Cal.App.3d 1160 [50 Cal.Comp.Cases 311]*.)

Lastly, defendant contends that the award of temporary disability indemnity should have been found to be limited by *section 4656(c)*. The WCJ acknowledges this in his Report, and the amendment to the award he recommends is appropriate and is applied as part of this Decision After Reconsideration. In all other respects the December 8, 2016 Findings And Award is affirmed.

For the foregoing reasons,

IT IS ORDERED as the Decision After Reconsideration of the Workers' Compensation Appeals Board that the December 8, 2016 Findings And Award of the workers' compensation administrative law judge is **AFFIRMED**, except that **[*41]** Paragraph (B) of the Award is **RESCINDED** and the following is **SUBSTITUTED** in its place:

AWARD

****

(B) Subject to the limitations of *Labor Code section 4656(c)(2)*, temporary partial disability payable at the rate of $ 271.22 per week for the period September 15, 2014 to December 15, 2015 less an attorney fee to applicant's attorney of 15% of the retroactive TTD paid and less wages made.

JAMES RUCKER

****

IT IS FURTHER ORDERED as the Decision After Reconsideration of the Workers Compensation Appeals Board that the case is returned to the trial level.

WORKERS' COMPENSATION APPEALS BOARD

Commissioner Marguerite Sweeney

I concur,

Commissioner Frank M. Brass

I dissent,

Commissioner Deidra E. Lowe

DISSENTING OPINION OF COMMISSIONER LOWE

I dissent. There is no substantial medical or vocational evidence that supports deviation from use of the Combined Values Chart (CVC) by adding the orthopedic and psychiatric permanent disabilities instead of combining them as provided in the 2005 Permanent Disability Rating Schedule (PDRS). The CVC should be used when there is no substantial medical or other evidence that supports use of the additive method, as in this case. Applicant is entitled to a finding of permanent disability **[*42]** pursuant to section 4660 based upon use of the PDRS and its CVC. (*Athens Administrators v. Workers' Comp. Appeals Bd. (Kite)* (2013) 78 Cal.Comp.Cases 213 [2013 Cal. Wrk. Comp. LEXIS 34] (***Kite***); *Borela v. State of California* (May 13, 2014, ADJ7181658) [2014 Cal. Wrk. Comp. P.D. LEXIS 217] (***Borela***).)

In *Kite*, the injured worker sustained injury to both hips. The Qualified Medical Evaluator (QME) reported in that case that there was a "synergistic effect of the injury to the same body parts bilaterally versus body parts from different regions of the body" and opined "that the best way to combine the impairments to the right and left hips would be to add them versus using the combined values chart, which would result in a lower whole person impairment." (*Kite, supra,* 78 Cal.Comp.Cases at p. 214.) The Appeals Board panel agreed with the WCJ that the expert opinion of the QME in *Kite* was logical and reasonable in explaining why adding the permanent disability caused by the injuries to each hip in that case was more accurate in establishing the injured worker's level of permanent disability than combining those percentages under the CVC.

The PDRS provides on page 1–10 that the CVC and its formula **[*43]** is "generally" used to combine multiple disabilities and the Labor Code provides that a PDRS rating "shall be prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule." (Lab. Code, § 4660(c) .) In *Kite*, use of the CVC was rebutted by the QME's expert medical opinion that the separate ratings for each hip should be added instead of combined in order to obtain a more accurate rating of the injury. (*Kite, supra,* 78 Cal.Comp.Cases at p. 216.) By contrast, the record in this case, unlike the record in *Kite*, contains *no* medical evidence that adding the orthopedic and psychiatric disabilities will provide a more accurate permanent disability rating than using the CVC to combine them as provided in the PDRS.

The only reason given by the WCJ for adding the psychiatric and orthopedic disabilities instead of combining them with the CVC is his belief that those disabilities do not overlap. However, the belief of a

WCJ is not evidence. In the absence of substantial medical or other evidence that supports use of the additive method, the PDRS provides for use of the CVC to obtain an accurate rating of the combined effect of the orthopedic **[*44]** and psychiatric disabilities.

The role of the WCJ in rating permanent disability is set forth in the Appeals Board's en banc decision in *Blackledge v. Bank of America (2010) 75 Cal.Comp.Cases 613* [*2010 Cal. Wrk. Comp. LEXIS 74*] (Appeals Board en banc) (*Blackledge*), and that role does not involve substitution of a WCJ's belief for substantial medical evidence. As the panel wrote in *Borela, supra*:

> In the absence of medical evidence that justifies an alternative approach, such as the QME's opinion in *Kite, supra*, there is no medical justification for the WCJ's rating instruction. Under [*Blackledge*], the WCJ's role in the context of a formal rating is to frame instructions, based on substantial medical evidence, that specifically and fully describe whole person impairments to be rated. The WCJ appropriated the role of the medical expert when she made a medical determination as to how to combine the separate impairments in the absence of specific medical evidence to substantiate her choice.

As in *Borela*, the WCJ in this case acted contrary to the principles set forth in *Blackledge* by appropriating the role of the medical expert and concluding that applicant's orthopedic and psychiatric impairments **[*45]** should be added instead of combined under the CVC. In the absence of medical evidence supporting use of the additive method, the role of the WCJ is to apply the PDRS, including the CVC, to determine the presumptively correct permanent disability rating. (*Blackledge, supra.*) Authorizing a WCJ to forego use of the CVC in the absence of substantial medical or other evidence and based only upon a belief that there is insufficient overlap between the disabilities defeats the purpose of the PDRS, which is to "promote consistency, uniformity, and objectivity" in rating permanent disabilities (*Lab. Code, § 4660*.)

Moreover, overlap is not the only reason the CVC exists to combine permanent disabilities caused by the injury to separate body parts. By combining the permanent disabilities, the CVC addresses the fact that the amount of indemnity due for each percentage point of permanent disability increases as the overall level of permanent disability increases. The CVC accounts for this difference by adjusting the values. If the disabilities are simply added together without supporting medical evidence instead of combined using the CVC, the resulting award of permanent disability indemnity will **[*46]** exceed the amount the employer is legally obligated to pay and "[t]he employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment" (*Lab. Code, § 4664(a)*.)

I also dissent from the view of the majority that applicant established that she is totally permanently disabled "in accordance with the fact" as provided in *section 4662(b)*. No medical evidence supports such a finding, and the reporting of applicant's vocational expert is not substantial evidence. To the contrary, the weight of the evidence, including the reporting of defendant's vocational expert shows that applicant's diminished future earning capacity is captured within the *section 4660* PDRS rating.

In opining that Ms. Martinez has a diminished future earning capacity of 100%, applicant's vocational expert Mr. Linvill wrote in his October 19, 2014 report that her ability to find alternative work is impacted by her lack of academic skill and lack of fluency in English. Nevertheless, he attributed the lack of alternative employment opportunities to the injury instead of those individualized factors. This is contrary to *Ogilvie* , where **[*47]** the Court wrote that the PDRS is *not* rebutted by evidence of "nonindustrial

factors such as general economic conditions, illiteracy, proficiency in speaking English, or an employee's lack of education" that limit future earning capacity. (*Ogilvie, supra, 197 Cal.App.4th at 1275*.)

By contrast, defendant's expert Ms. Tichner wrote in her June 8, 2015 report that applicant's lack of amenability to vocational rehabilitation is not due to the effects of her injury, but is instead "due to the effect of her functional illiteracy and inability to speak fluent English." As Ms. Tichner wrote, "[w]ere it not for these non-industrial factors, she would be able to access the jobs I selected in the preliminary report." Evidence that the injured worker's loss of future earning capacity was caused by nonindustrial factors precludes a finding that the scheduled rating is rebutted. (*Ogilvie, supra, 197 Cal.App.4th at p. 1275*; *Dahl, supra*, 240 Cal.App.4th at pps. 757–758.)

I would set aside the decision of the WCJ and enter a new finding of permanent disability pursuant to *section 4660* by applying the PDRS with use of the CVC.

WORKERS' COMPENSATION APPEALS BOARD

Commissioner Deidra E. Lowe

* * * *

LEXISNEXIS [*48] COMMENTARY

(November 13, 2017)

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Caution: This board panel decision has not been designated a "significant panel decision" by the Workers' Compensation Appeals Board. Practitioners should proceed with caution when citing to this board panel decision and should also verify the subsequent history of the decision, as these decisions are subject to appeal.

The Rules for Determining Permanent Disability Can Often Be Difficult to Predict

Labor Code Section 4660(d) provides that California's Permanent Disability Rating Schedule (PDRS) shall promote consistency, uniformity and objectivity when it comes to determining an injured worker's permanent disability. From reading this section, one could assume that the rules applicable to determining permanent disability in California Workers' Compensation System would be easy to navigate. However, *Section 4660(d)*'s stated mandate has not resulted in anything close to an easy to understand process when it comes to determining permanent disability.

Some of the difficulty lies in the fact that cases like *Almaraz v. Environmental Recovery Services/Guzman v. Milpitas Unified School District (2009) 74 Cal. Comp. Cases 1084 (Appeals Board en banc)*(*Almaraz/Guzman II) and Ogilvie v. City and County of San Francisco (2009) 74 Cal. Comp. Cases 1127 (Appeals Board en banc)*(*Ogilvie [*49] II*) specifically find that the 2005 Permanent Disability Rating Schedule can be successfully rebutted by either using other tables and chapters from the AMA Guides or in the case of *Ogilvie*, by using information completely outside of the PDRS.

There is also *Labor Code Section 4662* which provides that permanent and total disability "shall be determined in accordance with the fact..." Nowhere in the Labor Code is there such a broad definition

provided for permanent partial disability. Moreover, nowhere in the Labor Code is the phrase "in accordance with the fact..." explained or defined.

Accordingly, although the rules applicable to a permanent and partial disability case are somewhat clearer, as the case moves closer to the realm of permanent and total disability, the rules become less and less clear. This point is underscored by the recent Workers' Compensation Appeals Board (WCAB) panel decision in *Martinez v. Pack Fresh Processors, LLC*, ADJ8552281. The majority of commissioners in *Martinez* concluded that the Workers' Compensation Administrative Law Judge (WCALJ) did not have to follow the 2005 PDRS by using the Combined Values Chart (CVC) in combining applicant's physical and psychiatric **[*50]** injuries, but could instead simply add those disabilities together so as to arrive at a 100% rating.

Indeed, the majority did not conclude that the **physician** could choose to ignore the CVC and add the disabilities together (see *Athens Administrators v. Workers' Comp. Appeals Bd. (Kite) (2013) 78 Cal. Comp. Cases 213* (writ den.)) but that the **WCALJ** could use the additive approach consistent with the WCALJ's ability to determine permanent and total disability "in accordance with the fact..."

Ironically, in emphasizing that the 2005 PDRS is nothing more than a guide for determining the appropriate level of permanent disability, the majority cited a pre-2005 case that provided that the permanent disability caused by separate body parts can be added together when that results in a more accurate rating. Specifically, the majority found that adding them instead of combining them made particular sense to the extent the WCJ found that the permanent disability caused by the different body parts did not "overlap". As the dissent in *Martinez* pointed out, it could be argued that the question of whether the orthopedic and psychiatric conditions overlap could constitute a medical question to be addressed **[*51]** by the medical experts.

In conclusion, the *Martinez* case should remind the practitioner that when dealing with a serious permanent disability case, the WCAB may be more concerned with whether the outcome appears to reflect an accurate level of permanent disability than perhaps with the precise methodology used in arriving at that accurate level of permanent disability.

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February 25, 2019

RE: xxxxxxxxxxxxxxxxxx vs xxxxxxxxxxxxxxx
WCAB No.: ADJxxxxxxxx
DOI: CT
Claim No: xxxxxxxxxx

Dear Dr. :

You are the PQME in INTERNAL MEDICINE from Panel #xxxxxxx on the matter of xxxxxxx xxxxx. You have evaluated our client xxxxxxxxx xxxxx for disputed heart and cardiovascular system problems on 06/20/2018 and issued reports dated 07/18/2018 and 01/25/2019.

For reasons unknown, the records of Mr. xxxxx's treating cardiologist, xxxxxxxxx, M.D., were not enclosed in the records sent to you. You now will find those enclosed.

Please comment on the echocardiograms of 07/31/2018 and 03/10/2017. You will note they both indicate "mild left ventricle hypertrophy". The more recent also indicates mild enlargement of right ventricle and left atrium along with "Stage I diastolic dysfunction." See pp. 32-33; 41-42. From your exam, his Blood Pressure was Stage 1 Hypertension (152/98) despite antihypertensive medication. Applicant asserts that Mr. xxxxx should be placed in Class 3 of Table 4-2 due to the LVH alone. Please advise exactly where in Class 3 you place him considering the additional abnormal testing results.

You previously reviewed his emergency Left heart catheterization and coronary angioplasty with stent placement in the right coronary artery on 02/09/2017 following what was diagnose as "acute coronary syndrome". Pages 45-47. Although his ejection Fraction at that time was 35-40%, it appears to have improved to normal range of 62% per the 07/31/2018 echocardiogram. In a treadmill stress test of 12/05/2017, he was able to achieve 13.7 METS and >90% predicted heart rate, so it would appear that he has improved with regard to his coronary heart disease with the procedure of 02/09/2017. Applicant asserts that he nevertheless is best placed in Class 2 of Table 3-6a (as Class 1 is ruled out since he DID have coronary heart disease necessitating the angioplasty to repair the "100% right coronary artery occlusion"). Please advise where exactly in Class 2 he should be placed, given his clinical history and the permanent stents in his right coronary artery.

Additionally, you have noted that he is on the "blood thinner" Brilinta. You have advised that this is necessitated by the coronary heart disease and stent placement. Mr. xxxxx

has had significant symptoms from that medication including frequent nose-bleeds – one of which you observed. The AMA Guides, 5th, Section 9.6c at page 207 provides for a 10% impairment in this situation with similar medications:

> Long-term anticoagulation with warfarin or low-molecular-weight heparin increases bleeding risk and constitutes impairment in the 10% range
> .

AMA Guides, 5th, page 207. Please advise if you agree with this impairment – especially given that Mr. Luna is symptomatic.

Finally, as you have found applicant MMI/P&S, please provide the most accurate impairment rating per the AMA Guides, 5th edition. If you believe that a generic interpretation of the AMA Guides, 5th does not accurately capture the loss of function or impact on activities of daily living, please explain and use any method, page, chapter or figure in the AMA Guides, 5th that most accurately describes applicant's impairment. Please consider the Almaraz/Guzman and Cannon cases in this regard.

As you have found multiple body parts/systems to have been injured, please consider the Kite decision (wherein the left and right hip impairments were ADDED as opposed to combined with the Combined Values Chart due to their "synergistic" impact on the injured workers' activities of daily living.). Applicant contends that the impairments you have found herein to Coronary Heart Disease and Hypertensive Cardiovascular Diseased should be ADDED since it is the most logical, reasonable and, based on the facts, most accurately reflects the true level of disability sustained by the applicant given these serious cardiovascular diagnoses. This "additive approach" also is endorsed by the AMA Guides, 5th at page 10, paragraph 1:

> "A scientific formula has not been established to indicate the best way to combine multiple impairments. Given the diversity of impairments and great variability inherent in combining multiple impairments, it is difficult to establish a formula that accounts for all situations. A combination of some impairments could decrease overall functioning **more than suggested by just adding** the impairment ratings for the separate impairments**. . . .**"

AMA Guides, 5th, page 10 (emphasis added).

In this regard, please advise if (1) the Coronary Heart Disease overlaps with the Hypertensive Cardiovascular Disease; (2) whether they are separate conditions; or (3) whether they in fact have a "synergistic effect" such that Mr. Lara is at a geometrically greater risk of heart attack, stroke, co-morbidity, death or other serious cardiovascular event due to the combination of the conditions than if he had only just one of them.

Thank you for your assistance with this matter. Should you have any comments or questions please do not hesitate to contact the parties.

Sincerely,
Bret Graham

BG/sc
Enclosure (subpoenaed records xxxxxxx M.D.)
CC :

2015 Cal. Wrk. Comp. P.D. LEXIS 482

Workers' Compensation Appeals Board (panel Decision),

Opinion Filed August 4, 2015

W.C.A.B. No. ADJ6995506—WCJ Paul DeWeese (AHM); WCAB Panel: Commissioners Sweeney, Razo, Chairwoman Caplane

Reporter
2015 Cal. Wrk. Comp. P.D. LEXIS 482 *

Willie Sanchez, Applicant v. California Department of Corrections & Rehabilitation, State Compensation Insurance Fund, Defendants

Status:

CAUTION: This decision has not been designated a "significant panel decision" by the Workers' Compensation Appeals Board. Practitioners should proceed with caution when citing to this panel decision and should also verify the subsequent history of the decision. WCAB panel decisions are citeable authority, particularly on issues of contemporaneous administrative construction of statutory language [see *Griffith v. WCAB (1989) 209 Cal. App. 3d 1260, 1264, fn. 2, 54 Cal. Comp. Cases 145]*. However, WCAB panel decisions are not binding precedent, as are en banc decisions, on all other Appeals Board panels and workers' compensation judges [see *Gee v. Workers' Comp. Appeals Bd. (2002) 96 Cal. App. 4th 1418, 1425 fn. 6, 67 Cal. Comp. Cases 236]*. While WCAB panel decisions are not binding, the WCAB will consider these decisions to the extent that it finds their reasoning persuasive [see *Guitron v. Santa Fe Extruders (2011) 76 Cal. Comp. Cases 228, fn. 7 (Appeals Board En Banc Opinion)]*. LexisNexis editorial consultants have deemed this panel decision noteworthy because it does one or more of the following: (1) Establishes a new rule of law, applies an existing rule to a set of facts significantly different from those stated in other decisions, or modifies, or criticizes with reasons given, an existing rule; (2) Resolves or creates an apparent conflict in the law; (3) Involves a legal issue of continuing public interest; (4) Makes a significant contribution to legal literature by reviewing either the development of workers' compensation law or the legislative, regulatory, or judicial history of a constitution, statute, regulation, or other written law; and/or (5) Makes a contribution to the body of law available to attorneys, claims personnel, judges, the Board, and others seeking to understand the workers' compensation law of California.

Disposition: [*1]

The Petitions for Reconsideration are *denied*.

Core Terms

impairment, permanent disability, disability, reopen, original award, good cause, workers' compensation, hypertensive, prior award, cardiovascular, inequitable, reconsider, substantial evidence, panel decision, restaurant, disease, reasonable medical probability, medical evidence, heart disease, echocardiogram, enlargement

Headnotes

HEADNOTES

Petitions to Reopen-New and Further Permanent Disability-WCAB, affirming WCJ, held that there was good cause to reopen applicant youth counselor's stipulated award of 67 percent permanent disability in connection with cumulative injury to his heart, cardiovascular system and circulatory system from 5/30/2006 to 5/30/2007, to include presumed injury in form of left atrial enlargement that agreed medical examiner Gerald Markovitz M.D., had previously diagnosed but failed to include in his opinions underlying prior award, when WCAB found that Dr. Markovitz's 2009 report, upon which original stipulated award was based, did not take into account all available relevant medical information when describing applicant's permanent impairments and, therefore, did not constitute substantial evidence to support award, and that WCAB did not know of potential additional impairment at time of prior award, thereby rendering prior award inequitable. [See generally *Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 31.04[3]*, *31.05*; Rassp & Herlick, California Workers' Compensation Law, Ch. 14, §§ 14.04, 14.05, 14.08, 14.09.]

Permanent Disability-Rating-Combined [*2] Values Chart-WCAB, affirming WCJ, held that there was good cause to reopen applicant youth counselor's prior stipulated award of 67 percent permanent disability for new and further disability caused by left atrial enlargement, and that WCJ did not err by adding additional 21 percent permanent disability (based on 10 percent whole person impairment described by agreed medical examiner Gerald Markovitz, M.D.) caused by left atrial enlargement, rather than combining permanent disability ratings using Combined Values Chart, when WCAB reasoned that, while strict application of Combined Values Chart is *prima facie* evidence of level of disability, evidence may be rebutted by substantial evidence showing that different method of combining multiple impairments results in more accurate rating of disability, and WCAB believed that in this case finding of 88 percent permanent disability by adding impairments was supported by substantial medical evidence consisting of Dr. Markovitz's opinions regarding combined effect of applicant's medical conditions on his future, including increased risk of sudden death, and WCAB was persuaded that adding ratings for final rating of 88 percent most accurately [*3] reflected applicant's true level of permanent disability. [See generally *Hanna, Cal. Law of Emp. Inj. and Workers' Comp. 2d §§ 8.02[3]*, *[4][a]*, *32.03*A; Rassp & Herlick, California Workers' Compensation Law, Ch. 7, §§ 7.11, 7.12; The Lawyer's Guide to the AMA *Guides* and California Workers' Compensation, Chs. 3, 4, 5.]

Counsel

For applicant-Law Offices of Robert Nava & Bret Graham

Opinion By: Commissioner Marguerite Sweeney

Opinion

ORDER DENYING PETITION FOR RECONSIDERATION

We have considered the allegations of the Petition for Reconsideration and the contents of the report of the workers' compensation administrative law judge (WCJ) with respect thereto. Based on our review of the record, and for the reasons stated in the WCJ's report, which we adopt and incorporate, we will deny reconsideration.

For the foregoing reasons,

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

WORKERS' COMPENSATION APPEALS BOARD

Commissioner Marguerite Sweeney

I concur,

Commissioner Jose H. Razo

Chairwoman Ronnie G. Caplane

* * * *

REPORT AND RECOMMENDATION ON PETITION FOR RECONSIDERATION

I

INTRODUCTION

Date of Injury: May 30, 2006 to May 30, 2007

Age on DOI: 56

Occupation: Youthor

Parts of Body Injured: Heart, cardiovascular system and **[*4]** circulatory system

Identity of Petitioner: Defendant, State of California

Timeliness: The petition was timely filed on June 5, 2015

Verification: The petition was verified

Date of Findings & Orders: May 13, 2015

Petitioner's Contentions: Petitioner contends the WCJ erred by: 1) finding good cause to reopen a prior Stipulated Award based on the AME's acknowledged failure to discuss all of applicant's impairments prior to the original Award; 2) finding a specific heart condition (left atrial enlargement) to be compensable based on the presumption of compensability set forth in Labor Code section 3212.2; and 3) adding impairments as recommended by the AME instead of combining them as set forth in the Schedule for Rating Permanent Disabilities.

II

FACTS

The parties stipulated that applicant Willie Sanchez sustained injury to his heart, cardiovascular system and circulatory system arising out of and occurring in the course of his lengthy employment as a youth counselor for the State of California Department of Corrections and Rehabilitation (CDCR). Applicant was eventually evaluated by Agreed Medical Examiner (AME) Gerald Markovitz, M.D. on January 5, 2009, and Dr. Markovitz issued a report that **[*5]** same date.

On June 9, 2010, the parties submitted Stipulations with Request for Award to the Workers' Compensation Appeals Board (WCAB) for approval, stipulating *inter alia* that applicant had sustained 67% permanent disability as a result of his industrial injuries, and expressly indicating in Paragraph 9 of the Stipulations that "both parties agree that settlement is based on the AME report of Gerald Markovitz, M.D." Based on the parties' stipulations, Workers' Compensation Administrative Law Judge (WCJ) Tien Nguyen issued an Award of 67% permanent disability on June 9, 2010.

On May 17, 2012, applicant filed a timely petition to reopen "for new and further disability/good cause per Labor Code 5410 and 5803" and alleged that his "medical condition has worsened, resulting in additional temporary disability, permanent disability and/or additional medical treatment."

On March 1, 2013, applicant was re-evaluated by the AME, Dr. Markovitz, who issued a report that same date and concluded that applicant had an additional 10% whole person impairment (WPI) as a result of left atrial enlargement (LAE) which had not been discussed in his original report. The parties deposed Dr. Markovitz on August **[*6]** 14, 2014, at which time Dr. Markovitz testified that the LAE existed at the time of his initial evaluation in 2009 and the heart condition (and related impairment) should have been discussed in his original report, but was not.

On March 17, 2015 the case was tried and submitted on the issues of whether applicant had sustained injury in the form of hypertensive cardiovascular disease and right leg peripheral vascular disease in addition to the stipulated injuries; whether applicant had increased permanent disability since the original Award; apportionment; the applicability of a presumption of compensability; and attorney fees.

Findings and Orders were issued on May 13, 2015, finding *inter alia* that applicant did not sustain new or further disability; there was good cause to reopen the prior Award pursuant to Labor Code section 5803; applicant did not sustain injury in the form of hypertensive cardiovascular disease or right leg peripheral vascular disease; applicant's heart trouble, including but not limited to the diagnosis of LAE, was presumed compensable pursuant to Labor Code section 3212.2; and applicant sustained permanent partial disability of 88% without apportionment. Based **[*7]** on those findings, the prior Award was amended to reflect an accurate permanent disability rating of 88%.

Defendant's timely petition for reconsideration followed, asserting that there is no good cause to reopen the prior Award of 67% permanent disability, which should remain undisturbed, and even if there is, the LAE impairment should be combined with rather than added to the previously awarded permanent disability.

III

DISCUSSION

A. THERE IS GOOD CA USE TO REOPEN THE PRIOR AWARD

Applicant's primary contention at trial was that he had sustained new and further disability beyond the 67% permanent disability previously awarded. This judge found that he had not sustained new or further disability, and that finding has not been appealed. However, good cause to reopen the prior Award was found pursuant to Labor Code section 5803. [1]

Defendant relies on the 1980 appellate decision in Nicky Blair's Restaurant v. Workers' Comp. Appeals Bd. (Macias) (1980) 109 Cal.App.3d 941 [45 Cal.Comp.Cases 876], **[*8]** in which the Court held that "in order to constitute 'good cause' for reopening, new evidence (a) must present some good ground, not previously known to the Appeals Board, which renders the original award inequitable, (b) must be more than merely cumulative or a restatement of the original evidence or contentions, and (c) must be accompanied by a showing that such evidence could not with reasonable diligence have been discovered and produced at the original hearing [citations omitted]." (Id. at 956).

However, the California Supreme Court has defined "good case" more broadly, noting that "a variety of factors and circumstances may constitute the requisite 'good cause'", which may include new evidence such as that discussed in *Nicky Blair's Restaurant*, but may also include other considerations. The Supreme Court concluded that "any factor or circumstance unknown at the time the original award or order was made which renders the previous findings and award 'inequitable,' will justify the reopening of a case and amendment of the findings and award." LeBoeuf v. Workers' Comp. Appeals Bd. (1983) 34 Cal.3d 234, 241–242 [48 Cal.Comp.Cases 587]. In so doing, the Court also expressly recognized **[*9]** that Labor Code section 3202 requires section 5803 to be liberally construed by the courts with the purpose of extending the benefits of the workers' compensation statutes for the protection of persons injured in the course of their employment (*Id.*).

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[1] § 5803 provides that the Workers' Compensation Appeals Board (WCAB) has continuing jurisdiction over its awards and "may rescind, alter, or amend any order, decision, or award, good cause appearing therefor."

Most recently, 34 years after the decision in *Nicky Blair's Restaurant*, the same Court of Appeal held that good cause was shown under the *LeBoeuf* standard when a stipulated award did not reflect the applicant's true disability at the time of the award, noting that "if the stipulation does not adequately reflect the disability of the applicant, it should not be accepted by the workers' compensation judge as the basis for his or her award [citation omitted]." Benavides v. Workers' Comp. Appeals Bd. (2014) 227 Cal.App.4th 1496, 1501 [79 Cal.Comp.Cases 483]. In *Benavides*, the original award was based on an AME's opinion that was later shown to be inaccurate regarding the extent of applicant's disability. The Court noted that an expert's opinion which does not rest upon relevant facts cannot constitute substantial evidence, and that WCAB decisions must be supported by substantial evidence. Therefore, "whether the stipulation was the result of **[*10]** inadvertence, excusable neglect, or mistake of fact, the error justifies reopening the resulting award," and in that case, "the evidence clearly established that the stipulated award was inequitable." *Id.*

The present case is nearly identical to *Benavides*. The original stipulation to 67% permanent disability was expressly based on the medical report of AME Dr. Markovitz (Ex. X). [2]

After the petition to reopen was filed, the parties returned to Dr. Markovitz to address whether there was new and further disability. In a report dated March 1, 2013 (Ex. Y), Dr. Markovitz discussed an additional diagnosis of left atrial enlargement that he did not discuss in 2009, and opined that the "mild" LAE would rate at 10% WPI per the AMA Guides and that this rating "could be added to his prior impairment ratings."

The parties then deposed Dr. Markovitz on August 14, 2014. When asked whether the LAE was a new diagnosis, the AME replied, "Well, not exactly." (Ex. Z, 10:17–18). He then went on to explain that while the LAE existed at the time of the examination in 2009, based on a 2007 echocardiogram **[*11]** that the AME did review in conjunction with his original evaluation (Ex. X, p. 6–7), he did not make the formal diagnosis because LAE is a first stage of end-organ damage related to hypertensive heart disease but there was no indication that applicant had hypertension when evaluated by the AME. As a result, Dr. Markovitz felt that the LAE could as easily be explained by applicant's large size. On the other hand, he noted that it is possible applicant had some level of hypertension that was masked or successfully treated by the cardiovascular medications he was given after his heart attack. At present, he is unable to say within reasonable medical probability whether the LAE was caused by hypertensive heart disease that was successfully treated by the medications applicant received after his heart attack, or whether it was related to other factors. *See* Ex. Z, 10:24–13:15.

Regardless of its cause, however, the applicant does have LAE, which is a ratable abnormality (Ex. Z, 13:16–24). Moreover, Dr. Markovitz acknowledged in deposition that applicant had impairment related to the LAE at the time of a 2007 echocardiogram that was actually improved by the time of a 2012 echocardiogram (Ex. **[*12]** Z, 37:8–38:6). He further acknowledged that he should have added the LAE impairment to the prior ratings (Ex. Z, 15:19–25). This testimony was the basis for the finding that applicant did not have new or further disability, but was also a basis for the finding that there was good cause to reopen the original Award. The AME's 2009 report, upon which the original Award was expressly based, did not take into account all available relevant medical information when describing applicant's permanent impairments, and thus did not constitute substantial medical evidence. As a result, the original Award was not supported by substantial evidence. Whether the original stipulation to 67% permanent disability was the result of inadvertence, excusable neglect, or mistake of fact, it did not adequately reflect applicant's true disability at the time and was thus inequitable, and the error justifies reopening the resulting award.

The only difference between the facts in *Benavides* and the present case is that the AME in *Benavides* was entirely unaware of diagnostic test results that existed at the time of his original examination and which affected his opinion regarding the extent of applicant's disability. **[*13]** Here, Dr. Markovitz was aware at the time of his original examination of the 2007 echocardiogram that revealed LAE. Defendant correctly points out that the defining characteristic of good cause to reopen, even under the broadest interpretation of the *LeBoeuf* standard, is that some fact unknown at the time of the original award renders the original award inequitable. The parties cannot relitigate a decided issue based on evidence known at time, and the WCAB cannot change its mind without new facts or circumstances (Nicky Blair's Restaurant at 955–956). Defendant contends that applicant knew or should

[2] At the time of the original stipulations, Dr. Markovitz had only issued one report, dated January 5, 2009.

have known about the potential additional impairment lurking in Dr. Markovitz's 2009 report and had the burden to ask the AME about it before entering into any stipulations, and neither the applicant nor the WCAB can relitigate the issue now.

However, the question of what was known at the time of the original award refers to what was known *by the WCAB*. Reopening for good cause requires some evidence or ground, *not within the knowledge of the Appeals Board* at the time the original award was made, that renders the original award inequitable (Nicky Blair's Restaurant at 955–956). An award is **[*14]** a decision of the WCAB that must be supported by substantial evidence. Because of Dr. Markovitz's failure to discuss the LAE in his 2009 report and because the parties expressly relied on that report when stipulating to 67% permanent disability (which was an accurate rating of the impairments described by the AME at the time), the WCJ did not know of the potential additional impairment and was thus unaware that the AME report did not accurately reflect applicant's true disability. Unlike in *Nicky Blair's Restaurant*, where there was substantial medical evidence to support the original award, no such evidence exists here; if there were, there would be no good cause to reopen. As in *Benavides*, the only medical evidence here consists of the opinions of the AME, which have been shown to be erroneous at the time of the original award and the WCAB was unaware of that fact at the time. The evidence clearly establishes that the original award was inequitable, and whether that was due to inadvertence, excusable neglect, or mistake of fact on the part of the AME, the parties, and/or the WCJ, the error justifies reopening.

B. APPLICANT'S LEFT ATRIAL ENLARGEMENT (LAE) IS COMPENSABLE

Defendant next **[*15]** contends that the existence of additional impairment due to LAE is not good cause to reopen because the LAE is not industrially related. Defendant quotes at length from Dr. Markovitz's deposition testimony regarding causation of the LAE (Ex. Z, 10:24–12:2) and concludes that because Dr. Markovitz could not say within reasonable medical probability what caused the LAE, applicant did not meet his burden of proof.

Defendant acknowledges the "heart trouble" presumption of Labor Code section 3212.2 and did not appeal the finding that it applies in this case, at least to the extent that applicant was a CDCR employee to whom the benefit of the presumption accrues. However, defendant asserts that "there is still a requirement of a heart injury to allow for the presumption to take [e]ffect" (pet. for recon., 7:14) and "the presumption requires a finding the heart condition exists and then causation is presumed in favor of Applicant and must be rebutted by Defendants" (*Id.* at 8:19). Defendant then argues that "Dr. Markovitz could not find with reasonable medical probability whether or not Applicant had hypertensive heart disease" (*Id.* at 8:21).

In fact, Dr. Markovitz opined that applicant *does* ***[*16]*** *not* have hypertensive heart disease, and this judge made an express finding to that effect. What applicant *does* have is left atrial enlargement (LAE). Although the AME could not identify a cause of that condition within reasonable medical probability, there is no question based on Dr. Markovitz's March 1, 2013 report and August 14, 2014 testimony that the physical abnormality exists as revealed by objective echocardiogram results.

As a physical abnormality of the heart, it is clear that LAE constitutes "heart trouble" which is presumed industrial pursuant to section 3212.2. Because of that presumption, applicant does not have the burden to prove that it was industrially caused. Instead, defendant has the burden to prove that it was not industrially caused. As pointed out by defendant, Dr. Markovitz simply could not say one way or the other within reasonable medical probability. In the absence of any other medical evidence, defendant did not meet its burden of proof on this issue, and applicant's LAE was found to be compensable. It should also be noted that defendant stipulated, both at the time of the original award and at the trial on March 17, 2015, that applicant had sustained industrial **[*17]** injury to his heart and cardiovascular system.

C. PERMANENT DISABILITY WAS CORRECTLY CALCULATED

Finally, defendant contends that if good cause to reopen the prior Award is found and the Award is amended to include additional impairment due to applicant's LAE, that impairment should be combined with the prior

impairments using the Combined Values Chart in the 2005 Schedule for Rating Permanent Disabilities, rather than simply added to the prior impairments as this judge did.

The extent of permanent disability is a question of fact to be decided by the trier of fact. The decision must, of course, be supported by substantial evidence. It is well settled that in determining the extent of an injured worker's permanent disability, the primary goal is to assign a percentage that most accurately reflects the worker's true level of disability. While strict application of the Schedule for Rating Permanent Disabilities (including the Combined Values Chart used for multiple impairments resulting from a single injury) is *prima facie* evidence of the level of disability, that evidence may be rebutted by substantial evidence showing that a different methodology (within limits not relevant here), including **[*18]** a different method of combining multiple impairments, results in a more accurate rating of the worker's true disability. *LeBoeuf, supra*; *Milpitas Unified School District v. Workers' Comp. Appeals Bd. (Guzman) (2010) 187 Cal.App.4th 808 [75 Cal.Comp.Cases 837]*; *County of Los Angeles v. Workers' Comp. Appeals Bd. (LeCornu) (2009) 74 Cal.Comp.Cases 645* (writ den.); *Athens Administrators v. Workers' Comp. Appeals Bd. (Kite) (2013) 78 Cal.Comp.Cases 213* (writ den.).

Using the 2005 Schedule for Rating Permanent Disabilities, the 10% WPI described by Dr. Markovitz for the LAE adjusts to 21% permanent disability. Defendant does not dispute that rating, standing alone. [3]

Defendant's sole dispute is with the finding that the 21% should be added to the prior award of 67%, resulting in a final award of 88% permanent disability. Defendant contends that the 67% and 21% ratings should be combined using the Combined Values Chart, which would result in a final rating of 74%.

In his deposition, the AME agreed with applicant's counsel that there was a "negative synergistic effect" between the previously-rated impairments for heart arrhythmia and coronary disease and the additional impairment due to LAE, such that because of the particular combination of problems, applicant is at exponentially greater risk of sudden death than somebody with only one of the problems. Dr. Markovitz avoided providing an opinion regarding whether the impairments should be combined or added for rating purposes, apparently under an erroneous belief (suggested by defense counsel) that it was "a legal question." *See generally* Ex. Z, 16:1–18:1.

Although the AME would not answer the question directly, this judge **[*20]** believes the finding of fact of 88% permanent disability to be supported by substantial medical evidence consisting of the AME's opinions regarding the combined effect of applicant's medical conditions on his future, and giving the AME's opinions the great weight to which they are entitled. The court was (and is) persuaded that adding the ratings together for a final rating of 88% more accurately reflects applicant's true level of permanent disability, in an analysis similar to the one in *Kite, supra*. The court also found persuasive the argument set forth in applicant's March 17, 2015 Trial Brief, 4:17–6:23.

IV

RECOMMENDATION

It is respectfully recommended that defendant's Petition for Reconsideration be denied in its entirety.

Paul DeWeese

Workers' Compensation Administrative Law Judge

Dated: June 15, 2015

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[3] It should be noted that the AME obtained the 10% WPI from Table 4–2 on page 66 of the AMA Guides, which contains criteria for rating hypertensive cardiovascular disease, which the AME said applicant does not have. On the other **[*19]** hand, on page 8 of his March 1, 2013 report (Ex. Y), the AME noted that LAE is "the very mildest form of end organ damage" related to hypertensive heart disease, and such damage warrants a 10% WPI on Table 4–2. Therefore, the 10% WPI was found to have been reasonably applied from within the four corners of the AMA Guides to most accurately reflect applicant's true impairment, pursuant to *Guzman, supra*. Defendant has not directly objected to assigning 10% WPI to applicant's LAE.

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WORKERS' COMPENSATION
STRUCTURED SETTLEMENTS

Steven F Chapman
Call 1-800-845-2969

Structured Settlements and the MSA Process

STEVEN CHAPMAN CAAA Winter Convention 2019

History of Structured Settlements and MSA/CMS process

CMS recognized structured annuities from inception of set- asides as a tool to fund the MSA

Structured settlements are utilized to obtain and provide rated ages which assist in the present value cost analysis. Who determines the rated age? Are they always accurate? Who really benefits from rated ages?

Structured settlement annuities are utilized to provide PV cost of CMS approvals that call for seed and annual payments

Structured approvals of the MSA must come from CMS. What happens if you receive a lump sum approval? (see letter requesting breakdown into seed and annual payments}

How and why of seed money and annual payments in CMS approvals. Must the seed and annual payments be followed – can they be revised?

How are MSA's and CMS approvals priced out – What does CMS require? What does the Carrier require? What is best methodology for the injured worker?

Temporary Life vs. Guaranteed payments: Pros and Cons

Submission of MSA's

Who Submits MSA and When

What is a "Current MSA" and when does it turn "stale". Who determines this? What is this 6 month rule? Does CMS ever send a MSA back for being stale?

Non-Submit MSA's Pros and Cons. Who is at risk? How to minimize the risk.

What does CMS say about Non- Submit MSAs

What can you do as AA if you feel that the MSA is not accurate? What is accurate? What duty is owed to CMS? What duty is owed to the injured worker?

Are guaranteed MSA's the answer? Who is guaranteeing the MSA? What are the risks? Do they ever make sense? And – What exactly is being guaranteed?

Structured Settlements – Their Role in helping to determining future medical care

The optimum role of the structured settlement broker is one of facilitator

Structured Settlements are a powerful tool to assist all parties to a settlement in discovering the value of future medical care

How can structured settlements be utilized to help the parties uncover the true cost of future medical care

The MSA alone does not equal Future Medical Care

Detailed structured settlement packages can outline carrier's potential exposure through use of present value costs and inflation factors

Structured settlement can provide Carrier and AA with MSA value and the cost those elements of medical care missing from MSA

Structures can outline the non-Medicare medical components not addressed by the MSA.

Do MSA reports have to contain non-Medicare medical components? Are they required to? Who provides the MSA vendor with the non-Medicare medical components? Does CMS want to see the non-Medicare medical component? Would it affect their decision as to CMS approval?

Settlement annuities provide a common ground cost analysis between unrealistic discount rates used by the carrier and full value payout costs provided by the AA

Flexibility of the structure settlement tool allows for parties to negotiate various scenarios in real time to reach acceptable compromise positions

Structured Settlements and Non-Medicare Medical components to future medical care

Settlement packages can be designed to outline the Non-Medicare Medical needs

Who determines the Non-Medicare Medical needs? Who determines the Cost? Utilizing Life care planners. The Role of Carrier's Payment History. Resources for future medical care cost components. How to get doctors to participate in the process (see attached letter of life care plan components)

Are there co-pays, donut holes which are the responsibility of the injured worker? What are they? What if the Carrier tells you that there are no more co-pays and donut holes and that if there were, they have already been factored in the MSA?

Understand the payments being made as demonstrated in the Carriers Payment History and the Annual Amount being requested through the CMS annual amount.

What are good resources to utilize to determine future medical needs not listed in the MSA or CMS approval? What is the best way to outline these additional costs to the defendant?

Do you want to request that money missing medical care be added to the MSA or do you want it demanded as cash or future monthly/annual payments? Structured Settlements can provide opportunities those various options

Structured Settlements can provide for guarantees to the additional monies not in MSA or CMS approval.

What if Carrier is requesting/requiring Reversion of some of the money in settlement?

Professional Administration

Does it make sense?

What is Professional Administration?

Why did CMS recently come out and "promote" the use of Professional Administration for MSA's? What does CMS expect from injured workers? From their Counsel?

Is it beneficial for the injured worker to utilize professional administration? Pros and Cons Costs? Flexibility of contract? Other services beyond just MSA compliance?

How can Professional Administration help the injured worker deal with an unknown future medical environment?

Can professional administrator assist with non-Medicare medical needs?

What resources can be provided by the Professional Administration company to assist AA's in their quest for accurate future medical costs?

How can you be sure that Professional Administration company is not denying future medical care when there is a reversionary clause to the MSA?

Can you engage in Professional Administration at a later time if you didn't initially want that option at the time of settlement? How would that work?

OR CARRIER INTERNALLY WANTED TO SETTLE @ 115,000 WENT TO GET CMS Approval & COMES back @ 110,959

Why Are Structures Beneficial?

IT CAN SAVE THE SETTLEMENT

Example: Case Settled for $115,000 Contingent upon CMS approval of $22,773 MSA.

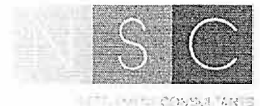
However, CMS comes back with $110,959. Deal was DEAD! The employer refused to give additional settlement authority.

However, the Deal was revived by Structuring the MSA

The Structured MSA freed up enough cash to cover Atty's Fees and still provide the Applicant with $35,000 cash up front

D.O.B.: 7/16/1964
Package C

Payment Description	Costs	Guaranteed Payout	Expected Payout
CASH AT SETTLEMENT	$35,015	$35,015	$35,015
ATTORNEY FEES	$17,250	$17,250	$17,250
MSA SEED	$6,341	$6,341	$6,341
ANNUAL CONTRIBUTION TO MSA ACCT FOR 34 YRS CERTAIN **$3,077 payable annually, beginning 2/4/2018 for 34 years certain only.**	$56,394 62,735	$104,618 BUYS →	$104,618 110,959
TOTAL	$115,000	$163,324	$163,324



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Medicare Part D – 2019 Schedule

Prescription Drug Coverage
(Coinsurance & the Donut Hole)

- **$0.-$415: Beneficiary pays all. Medicare pays $0. This is the yearly deductible**
- **$416-$3,820: Beneficiary pays 25%, Medicare pays 75%. This is Coinsurance for the Initial Coverage Limit**
- **$3,821-$7,653.75: Beneficiary pays 100%. This is the Coverage Gap (The Donut Hole)[1]**
- **Above $7,653.75: Beneficiary pays the greater of: a 5% Coinsurance or a Copayment ($3.40 for generics, $8.50 for brand names) for each covered drug until the end of the year. This is the Catastrophic Coverage**

- **$5,100 is the Beneficiary's Total Out-Of Pocket Costs – excluding the monthly Part D Plan Premium & prior to catastrophic coverage**
- **Beneficiary pays an additional monthly premium ($15 - $120) that varies depending on the Part D Plan they choose**
- **Consider $400/mo Non-Medicare Drug costs for Settlement Proposals to cover the Out-Of –Pocket Costs (Donut Hole, Copayments & Deductible) for applicants with high prescription drug expenses.**

[1] In plan year 2019, Medicare beneficiaries who reach the Coverage Gap (Donut Hole) will receive a 63% discount on generic drugs purchased and a 75% discount on brand name drugs. The discount is only for Medicare Part D drugs included in their Part D prescription drug plan formulary.

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The Truth About the Donut Hole

There has been a lot of misinformation about what will happen to the Medicare Part D (prescription medication) Donut Hole with the passage of the Affordable Care Act (aka Obamacare).
Here are some important FAQ's:

Q: Has the Donut Hole been eliminated?
A: NO

Q: Will Donut Hole costs ever become $0.00?
A: NO

Q: Will there be a gradual decrease in Donut Hole costs?
A: Yes, there will be a gradual decrease until 2020 at which time a 25% coinsurance cost will be in place.

By 2020, the Donut Hole will have transformed from a 100% cost (as originally designed) to a 25% cost to the beneficiary.

The beneficiary will continue to have all of the following Part D prescription medication costs:

- **Deductible ($415 in 2019)**
- **25% Coinsurance (up to $3,820 in 2019)**
- **Donut Hole (up to $7,653.75 in 2019)**
- **Part D Plan monthly premium ($15 - $120 depending on plan)**

Thus, there will continue to be substantial non-Medicare Part D costs for applicants that settle their workers' compensation claims through 2020 and beyond. Your Structured Settlement Broker can break down these costs for you.

"There is More to Future Medical than just the MSA"

Common Services/Supplies Not Covered By Medicare Parts A & B

It is Important to Incorporate Non-Medicare Medical Costs into your Settlement Demand

Not Covered	Exceptions/Explanations
Acupuncture	
Alternative Therapies	Including massage therapy, chelation therapy, biofeedback and holistic medicine
Blood - limited	The first three pints are not covered. After the first three pints, beneficiary pay 20% coinsurance of the Medicare approved amount
Chiropractic Services - very limited	Medicare covers manipulation of the spine if medically necessary to correct a subluxation. Beneficiary pays 20% coinsurance. You pay all costs for any other services or tests ordered by a chiropractor (including x-rays and massage therapy)
Common Medical Supplies - Like Bandages and Gauze	
Concierge Care	Also called concierge medicine, retainer-based medicine, boutique medicine, platinum practice or direct care.
Cosmetic Surgery	Unless it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast reconstruction covered for a mastectomy because of breast cancer.
Custodial Care	Not covered when that is the only kind of care needed. Defined as assistance with activities of daily living such as bathing and eating when provided by unskilled individuals
Deductibles, Coinsurance & Copayments	Deductible-the amount that must be paid before Medicare begins to pay. Coinsurance-your percentage share of the costs. Copayment-your fixed share of the costs
Dental Service	Medicare does not cover routine dental care, dentures or most dental procedures
Durable Medical Equipment - limited	Provided under Part B but there is no coverage if the beneficiary's doctor or supplier is not enrolled in Medicare. If covered, beneficiary pays 20% coinsurance.
Emergency Services	Medicare Part "B" only pays for an injury or illness that requires immediate medical attention to prevent a disability or death. There is a set copay for the emergency room visit, 20% for the doctor's services and the Part B deductible applies.
Eye Exams, Eyeglasses and Contact Lenses	Medicare does not cover routine eye exams. Some eye tests and screenings are covered. One pair of eyeglasses with standard frames (or contact lenses) only after cataract surgery that implants an intraocular lens.
Foot Care	Routine foot care is not covered
Gym Memberships	
Health Care While Traveling Outside the U.S.	Rare exception for hospital care in Canada or Mexico
Hearing Aids & Exams	Medicare does not cover routine hearing exams or hearing aids
Home Modifications	
Home Repairs/Maintenance	
Immunizations - limited	Medicare currently provides coverage for flu, pneumonia, and hepatitis vaccinations. Other types of vaccinations and immunizations are typically not covered by Medicare

Compliments of Steven F. Chapman

Structured Settlements

800-845-2969

Stefanie V. Plotkin ***www.workcompsettlementconsultants.com*** ***Gregg M. Chapman***

"There is More to Future Medical than just the MSA"

Common Services/Supplies Not Covered By Medicare Parts A & B

(Continued From Front)

Not Covered	Exceptions/Explanations
Incontinence Supplies & Adult Diapers	
Long Term Hospital Care	Beneficiary pays: $1,364 yearly deductible; Coinsurance of $341/day for days 61-90; $682/day for days 91-150; all costs for each day beyond lifetime reserve days
Long Term Inpatient Mental Health Care	Not covered after a total of 190 days in a specialty psychiatric hospital during beneficiary's lifetime
Long Term Skilled Nursing Facility Care	Beneficiary pays coinsurance of $170.50 per day for days 21 – 100 per benefit period. Not covered beyond 100 days per benefit period
Over - The - Counter Medications	
Prescription Drugs - limited	Most prescription drugs, as well as off-label uses, are not covered under original Medicare. Beneficiary must buy Part D for coverage
Psychiatric Care - limited	Beneficiary pays 20% coinsurance for outpatient treatment (such as counseling or psychotherapy) in a doctor's office setting
Routine Physical Exams	
Routine Screening Tests	Most screening tests like checking your hearing are not covered
TENS Unit	Medicare dropped coverage of transcutaneous electrical nerve stimulation (TENS) for chronic low back pain
Transportation (routine)	

"Even if Medicare covers a service or item, you generally have to pay your deductible, coinsurance and copayment"*

Medicare premiums, deductibles and coinsurance rates for 2019:

- Part A (Hospital Ins.) No Monthly Premium if Medicare taxes paid while working (some exceptions)
- Part B (Medical Ins.) Monthly Premium: $135.50/mo. for individuals with income of $85,000 or less

- Part A Deductible: $1,364 Paid by beneficiary for each benefit period.
- Part B Deductible: $ 185 per year. After the deductible is met, beneficiary typically pays 20% coinsurance of the Medicare-approved amount of the service

Above information is based on Original Medicare.

- A Medigap (Medicare Supplemental Insurance) policy, sold by private insurance companies, can help pay some of the health care costs ("gaps") that original Medicare doesn't cover, like copayments, coinsurance and deductibles

- Sources: Medicare.gov, Medicare publications: "Medicare & You 2019"*, "Medicare 2019 Costs"

Please contact us to assist you in determining the present value of the above items

Compliments of Steven F. Chapman

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800-845-2969

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5.2 Structured WCMSAs

A WCMSA can also be established as a structured arrangement, where payments are made to the account on a defined schedule to cover expenses projected for future years. In a structured WCMSA, an initial deposit is required to cover the first surgical procedure or replacement and two years of annual payments. The initial deposit ("seed money") is followed by subsequent annual deposits (or a shorter time period if CMS agrees to such) based on the anniversary of the first deposit. If in any given coverage year the deposited funds are not exhausted (i.e., used up, spent), they are carried forward to the next period and added to the next annual deposit. The whole fund, including carry-forwards, must be exhausted before Medicare will pay primary for any WC injury-related medical expenses. If the fund is exhausted appropriately in a given annual period, Medicare will pay primary for further WC injury-related medical expenses during that period. In the next annual period, the replenished WCMSA funds again must be used, until the WCMSA amount is appropriately exhausted.

MSA Account Funding Options

- Funding the MSA using an Annuity
  - Structured Settlement Broker–Free valuable resource
  - Rated Age – Reduces the amount of the MSA
  - Provides more money for claimant's use
  - Lessens the chance of misuse of MSA funds
  - Seed Money + annual payment
- Funding the MSA with a lump sum
  - Entire MSA amount is deposited into account upon settlement of claim

(PUT APPLICANT'S ATTORNEY'S LETTERHEAD HERE)

December 11, 2018,

Centers for Medicare & Medicaid Services
c/o Benefits Coordination & Recovery Center
P.O. Box 138899
Oklahoma City, OK 73113-8899
Fax: 1-405-869-3306

Attn: WCMSA Proposal/Final Settlement

RE: JANE DOE
Medicare ID/SSN: *****5555A
Date of Injury: 08/10/2004
CMS Case Control Number: WC1234567890123

Dear Sir/ Madam:

This letter is to confirm that I, Jane Doe and I, Larry Lawyer are aware of and approve the request to change the payout of the WCMSA from a lump sum to a structured annuity.

Should further details or explanation be required, please contact the undersigned. Thank you for your consideration.

Sincerely,

____
Larry Lawyer, Esq.
Attorney for Jane Doe

____
Jane Doe
Applicant

Optimizing MSAs: Before & After Settlement

Daniel M. Anders, JD, MSCC, CMSP, Chief Compliance Officer
Tower MSA

Marques Torbert, Chief Executive Officer
Ametros

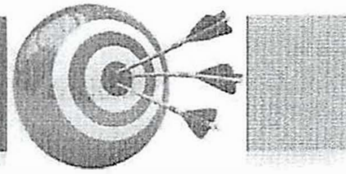
Meet the Presenters

- Dan Anders
- Chief Compliance Officer, Tower MSA

- Marques Torbert
- Chief Executive Officer, Ametros

2

Learning Objectives



- Identify MSA cost drivers and applying clinical interventions for reductions.
- Limiting MSA costs through the drafting and submission process
- MSA Professional Administration's role in balancing interests of employer and injured worker.
- Protecting and extending MSA dollars through Professional Administration.

3

Intervention Driven MSA Partner

- MSA partner and client clearly communicate claim information and opportunities to lower MSA costs.
- MSA partner identifies throughout MSA handing opportunities to appropriately reduce MSA amount.
- MSA partner mitigates exposure through clinical processes.
- MSA partner uses benchmark analytics to measure results

4

Pre-MSA Report Identifies Intervention Opportunities

- Pre-MSA Triage
  - Projected MSA cost based on current medical and pharmacy treatment regimen
  - Snapshot view of MSA exposure
  - Overview of inappropriate, unnecessary treatment and cost drivers that may impact MSA and settlement
  - Case-specific recommendations based on jurisdictional issues and opportunities
  - Action plan and next steps to optimize settlement outcomes before the MSA report is prepared

7

MSA Report Cost-Saving Optimiz Medications

- PRN/As Needed medications
- Generic Alternatives
- Opioid overuse
- Inconsistences between medical records and Rx history
- Unclear whether medication still being prescribed.
- Prescriptions written, but not filled.
- Related vs. Unrelated medications

8

2018

Re:
Claim #:

Dear

MEDICATION RATED AGE

Attached, please find the MSA Update for the above-captioned claim. The MSA Update resulted in a decrease of approximately $283K primarily due to changes in the prescription medication regimen and a decrease in Claimant's life expectancy. This MSA Update was produced in line with two of the four special criteria that CIGA is tracking. This case involves high dollar medication exposure and there have been no treatment records for the past six months. We recommend you review this case with your supervisor prior to proceeding with settlement. Please advise if you will be seeking CMS submission of this MSA and, if so, we will update it accordingly.

Below are a few items to keep in mind:

1. **Dates of Injury**. A second date of injury was listed as 09/15/10. We utilized only the 08/15/10 date per the referral. If there are any other dates of injury to be included in the MSA, please let us know.

2. **Compensable Body Parts/Conditions**. The Large Loss Report listed head, cervical spine, thoracic spine, lumbar spine, right foot, psyche, and dental as compensable body parts/conditions. There was no record of any recent dental problems or treatment. Records also noted Claimant had issues with the right shoulder (found compensable by the orthopedic AME), right hand, right knee, and urinary retention and adrenal insufficiency due to the traumatic brain injury. As such, these conditions were listed as industrially related. If there are any additional compensable body parts/conditions to be included in the MSA, please let us know.

3. **Medical Treatment**. There were very few actual treatment records provided from and none of those records were recent. At the time of the most recent records, Claimant was treating with Dr. ., Internal Medicine. The most recent lab requisition dated 11/07/17 listed Dr. name. Please be aware that CMS is requesting updated medical records in many cases, including records related to all alleged industrial conditions, even if the carrier has not paid for the treatment. CMS has indicated that AME reports are not substitutes for actual medical records. CMS may not rely on the opinions expressed in the AME reports and may rely on more recent treatment records obtained by development. CMS will develop for records from whomever is

currently treating Claimant. CMS may not limit their request for documentation to workers' compensation treatment providers but may very well also request medical records from Claimant's primary care physician or other non-industrial treatment providers. A request for additional documentation will result in a delay in the review process.

4. **Prescription Medications**. The prescription payment history was blank. Please be aware that CMS is requesting more detailed two-year prescription payment histories, printed within six months of the date of submission, if there are no recent payments on the prescription history provided with the submission. The most recent list of prescription medications on file was from June 2017 and included levetiracetam 1000mg twice daily, fludrocortisone acetate 0.1mg daily, trazodone HCL 50mg at bedtime, Vimpat 100mg twice daily, and zonisaroide 400mg (4-100mg) at bedtime. There were several other medications listed which appeared to be related to nonindustrial conditions and those medications were not included in the MSA. **As such, we recommend confirmation of Claimant's current prescription medication regimen.** CMS is including medications utilized during the past two years of treatment unless noted to have been discontinued and is including medications listed in treatment records that are not on the prescription payment history. Please consider the following items:

    a. **Zoloft (Sertraline HCL) (potential increase $23K).** The most recent list of medications from June 2017 did not list Zoloft (sertraline) as a current medication. As such, this medication was not included in the MSA. Inclusion would result in an increase of approximately $23K. We recommend confirmation if this medication is in use.

    b. **AWP versus CA WC Pharmacy Fee Schedule Pricing (potential increase $41K).** We allocated for prescription medications utilizing CA WC Pharmacy Fee Schedule. If subject to CMS' review and AWP pricing, this would result in an increase of approximately $41K.

5. **Resolved Body Parts/Potential for Additional Diagnostic Testing (potential increase $6K).** If a body part is mentioned, but resolved, CMS could still include future diagnostic testing for the resolved body parts. In Dr. s 09/28/15 AME, he assigned impairment ratings for the cervical spine, lumbar spine, and right shoulder. As such, we only included diagnostic studies related to those orthopedic body parts and did not include diagnostic studies for the thoracic spine, right foot, right hand, or right knee. Inclusion of diagnostic studies for those body parts would result in an increase of approximately $1K to $1.5K per body part or approximately $6K for all those body parts.

6. **Potential for Psychotherapy and/or Cognitive Behavior Therapy (potential increase $2K).** Claimant has been diagnosed with altered mental status, behavioral disorder/psychosis, posttraumatic head syndrome, cognitive disorder, and major depressive disorder. Dr. was managing Claimant's psychotropic medications (currently trazodone); however, on at least two occasions, Claimant was evaluated by a psychiatrist. Once during a hospital stay in June 2017 due to major depression and acute encephalopathy and once during a prior similar hospital admission in 2015. As such, we included psychiatric follow up on an annual basis to monitor Claimant's psychiatric conditions and treatment. CMS could also potentially include some cognitive behavior therapy and/or psychotherapy which could result in an increase of approximately $2K. We did not include this treatment as there has been no record that Claimant has undergone any recent psychotherapy or cognitive behavior therapy in recent years.

7. **Potential for Inclusion of Additional Occupational and/or Physical Therapy (potential increase $2K to $4K).** CMS could potentially include additional physical and/or occupational therapy. This would result in an increase of approximately $2K to $4K.

8. **Potential for Injections (potential increase $4K or more).** Dr. Berman's 2015 AME noted Claimant could possibly require "injections" in the future. There was no record that Claimant has received any injections to any body part. As such, no injections were included in the MSA. Inclusion of a series of 3 epidural steroid injections would result in an increase of approximately $3K. Inclusion of a series of 6-12 right shoulder steroid injections would result in an increase of less than $1K.

9. **Potential for Inclusion of Urine Drug Testing (potential increase $2K to $9K).** Despite the fact that Claimant is not being prescribed opiate/narcotic medications, there is a slight chance that CMS could still include periodic urine drug testing. This could result in an increase of approximately $2K to $9K depending on the frequency of testing.

10. **Dental Conditions/Treatment.** There was no record of any dental conditions and no current dental treatment plan. Medicare generally does not pay for dental treatment; however, they will pay for dental services that are an integral part either of a covered procedure or for extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw. Medicare will also make payment for oral examinations, but not treatment, preceding kidney transplantation or heart valve replacement surgery, under certain circumstances. Most all other dental treatment would not be covered by Medicare. If there is an updated dental treatment plan available for review and you would like to update the allocation, please advise us.

11. **Potential Need for Future Higher Level of Care (potential increase $8K or more).** If Claimant's condition were to deteriorate, he might require a higher level of care, such as a skilled nursing facility. Based on information available at www.genworth.com, the average cost of skilled/nursing home care per day is approximately $275 per day and average monthly cost of approximately $8K for a semiprivate room.

12. **Potential for ER Visits and/or Hospital Stays (potential increase $3K to $15K).** The records from i ,r noted Claimant was hospitalized in June 2017 due to hypertension and acute encephalopathy after an altercation with another resident at the facility. Claimant was evaluated by a psychiatrist during this admission. He was also discharged for a short stay at a skilled nursing facility after this admission. A similar incident and hospital stay occurred in 2015 after an altercation with a resident, but there was no mention of treatment at a skilled nursing facility after discharge. It is possible that Claimant could require some emergency department visits and/or hospital stays in the future. If CMS included these in the MSA, it would result in an increase of approximately $1K to $5K per visit and the inclusion of approximately 3 visits/stays.

13. **Board and Care.** Claimant is residing at for board and care. The most recent documentation on file indicated that the cost of care is $1,059.37 per month in 2018 for basic rent and assistance with medications. Based on prior payments, this price has increased approximately $13 per year in recent years. As such, we allocated for one year of the current pricing followed by annual increases of $13 per year until the last year of Claimant's life expectancy. This was a significant decrease in pricing compared to the prior non-Medicare expense allocation (**a decrease of approximately $389K**).

14. **CMS Submission.** If you would like to know the status of the prior MSA that was submitted to CMS, please deliver the attached CMS release and have Claimant and/or his attorney return a signed copy directly to our office. Once received, we can obtain the status of the prior MSA from CMS. If CMS submission is to be requested, the prior vendor will have to file to withdraw their MSA and then we would be able to move forward with submission of the updated MSA to CMS. **As noted above, CMS would likely develop for more updated treatment records and prescription payment histories if subject to their review.**

Thank you for your referral. Please do not hesitate to contact us by phone at 3, or by email at when we can be of further service.

Very truly yours,

, JD

12069 JEFFERSON BLVD.
CULVER CITY, CA 90230
PHONE: (800) 845-2969
FAX: (310) 450-3132

NATIONAL SETTLEMENT CONSULTANTS
STEVEN F. CHAPMAN
STEFANIE V. PLOTKIN, CSSC
GREGG CHAPMAN, ESQ.

FAX

To:	Applicant's Attorney	**From:**	Steve Chapman
Fax:		**Pages:**	2
Phone:		**Date:**	December 30, 2018
Re:	Applicant's Future Medical Needs	**CC:**	

☐ **Urgent** ☑ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

● **Comments:**

Dear Applicant Attorney:

As we discussed yesterday, I am providing you with a list of categories that are utilized in the creation of a life care plan. I have had success in the past by having the Treating Doctor address the following categories in as much detail as possible. Please review the items below and then give me a call so we can discuss how to use this list to create a demand to present to the Work Comp Carrier.

1. Projected Evaluations
2. Projected Therapeutic Modalities i.e. Dr. Visits, Pain Management Visits, P/T, etc.
3. Diagnostic Testing
4. Wheelchair/Mobility/Maintenance
5. Orthotics/Prosthetics
6. Orthopedic Equipment
7. Durable Medical Items
8. Aids for Independent Function i.e. crutches, grab bars, handheld shower, etc.
9. Supplies

12:22 PM 12/12/18

10. Medication

11. Home health Care

12. Health and Strength Maintenance

13. Transportation

14. Possible Complications

The Doctor needs to be as specific as possible in regards to frequency, and cost (if known) to any and all items.

You can always reach me on my cell: 310-480-5742

Sincerely,

Steven F. Chapman, Esq.

MEDICAL SETTLEMENT SPECIALISTS, LLC.

ann@medicalsettlementspecialists.com
1968 S. Coast Hwy
Laguna Beach, CA 92651

Ann Sandstrom, CWCP, MSCC, CMBP, CMRS, BCNM
Medical Valuation Specialist
Certified Workers' Compensation Professional
Medicare Set-Aside Certified Consultant
Certified Medical Billing Professional
Certified Medical Reimbursement Specialist

Ph. 424-644-6002
Fax 720-292-1866

CONFIDENTIAL ATTORNEY WORK PRODUCT

FUTURE MEDICAL SETTLEMENT VALUATION

November 28, 2018

Esq.

RE:
DOB: **December 13, 1964 (53)**
DOI: **October 9, 2016**

Dear Ms. Porrazzo:

Thank you for the opportunity to review the t matter for a Future Medical Settlement Valuation and review of the Life Care Plans (LCP) issued by Dr. and . The medical record is extensive and is reported in detail elsewhere. Issues of permanent impairment, apportionment, and causation can be addressed upon request. The information contained herein is for settlement purposes only and not to be considered a formal Medicare Set-Aside proposal or recommendation for medical care. Please consult with Mr. his physicians if further clarification is needed regarding future medical needs.

Mr. sustained multiple catastrophic compensable injuries on October 9, 2016. Claim related diagnoses include, but are not limited to: Traumatic spinal cord injury (SCI), upgraded to T6 paraplegia; T1 motor bilaterally, L2 sensory on the right T12 sensory on the left, incomplete AISA-C SCI, chronic neurogenic pain, neurogenic bowel requiring gastrointestional (GI) prophylaxis, neurogenic bladder, history of deep vein thrombosis, history of inferior vena cava filter placement, decompressions laminectomies, evaluation epidural hematoma, T9-L2 spinal

fusion, right tibial plateau fracture pinning, left scrotal laceration and repair, neurogenic erectile dysfunction, pressure wounds, left wrist fracture s/p open reduction and internal fixation, hemorrhoids, multiple rib fractures, recurrent urinary tract infections, history of clostridium difficile diarrhea (c-dif), autonomic hypotension, dyslpididemia, acid reflux, hypotension, spasticity, muscle cramps, tinea cruris, impaired activities of daily living (ADLS) requiring attendant care, impaired mobility and impaired skin sensation.

Estimated Charges for Future Medical Recommendations

Charges in this valuation are case-specific to Mr. and consider his diagnoses, co-morbidities and other claim-related factors. This analysis provides a reasonable estimate for items and services based on information that is currently available. Given the complex nature of Mr. s multiple SCI-related medical conditions and associated impairments, Mr. will require life-long care as noted by Dr. ad by

Individuals with the levels affected by Mr. SCI may be prone to autonomic dysreflexia and orthostatic hypotension. Spasticity and other sequela can be progressive and may result in the increased need for attendant care over time. Mr. currently receives 16 hours of attendant care per day as recommended by Dr. This is required for evening and night care to assist with position changes and to allow Mrs. the ability to sleep through the evening, as she provides frequent or stand-by assistance for Mr. throughout the day. It is my understanding that this requirement is expected to continue moving forward.

In preparation for a Compromise and Release settlement of medical benefits, this valuation includes consideration of all medical care, services, and items that would be reasonably required to cure or relieve the effects of the industrial injury(ies) over Mr. life expectancy, and to which the rights to receive active payment by the carrier would be waved. My findings are based on review of the medical records, review of the life care plans submitted by and Dr. nd my conversation with and Merritt.

I was advised that Mr. is currently not Medicare eligible and has no reasonable expectation of becoming a Medicare beneficiary within the next 30 months. Therefore, it is unlikely that this case will meet the Center for Medicare and Medicaid Services (CMS) review thresholds and no formal Medicare Set-Aside will be submitted for approval.

The LCP by was performed in November of 2017 and therefore calculated at 2017 California Official Medical Fee Schedule rates where applicable. The fee schedule has changed for 2018 and is reflected in this analysis. Dr. n provided his LCP calculated at actual charges. These typically run 30-70% higher than the fee scheduled rates and 2018 rates can be provided upon request.

Once Mr. enters post-settlement medical care, he will typically be charged retail value (cash pay) for future claim-related medications and medical treatment as his medical providers are not required to accept California Division of Workers' Compensation fee-scheduled payments post-settlement. Nor would Mr. Merritt have access to the negotiated discounts for medical care obtained by the carrier.

November 28, 2018

A non-rated life expectancy was calculated using the National Vital Statistics Reports, Vol. 66, No. 4, August 14, 2017; Table 1. Life table for males: United States, 2014. Charges listed herein are in today's dollar. Detailed information regarding rated age, cost of living adjustments, and present value calculations can be obtained from outside sources such as a structured settlement broker.

My findings can be updated if additional information is received. A formal Medical Set-Aside (MSA) submission would require comprehensive review of the medical record and may warrant additional items for inclusion. A non-allocation review can be provided upon request if an MSA will be submitted to CMS for approval. Charges noted herein may change if additional medical information, billing and/or pharmaceutical logs become available.

Medical Services: *NOS = Not otherwise specified by physician.* **Estimates are rounded to the nearest whole number.*	**Recommended by**	**Frequency**	**For # of years 27.3**	**Charge per service***	**Extension***
Primary care follow up	Dr. LCP	4 per year	27.3	$149.00	**$16,271.00**
Ortho follow up	Dr.	2 per year	27.3	$149.00	**$8,135.00**
Urology follow up	Dr. F	2 per year	27.3	$149.00	**$8,135.00**
Neurology follow up	Dr.	Estimate 1 per year	27.3	$149.00	**$4,068.00**
Psychological follow up for life transitions	Mr.	Estimate 15	27.3	$175.00	**$2,625.00**
Cognitive behavioral therapy	LCP	20 over LE	NA	$175.00	**$3,500.00**
Non-hospital wound care eval and treat prn	Dr. '	60 over LE	NA	$122.00	**$7,320.00**
Shoulder injections	Dr.	2 over LE	NA	$127.00	**$254.00**
Cardiac follow up	Dr.	Estimate 1 per year	27.3	$149.00	**$4,068.00**
					$54,376.00
Hospitalizations and Procedures:					
ER visits **Would likely be much higher than that listed in LCP unless this would be direct admit from ER. See below "other considerations"*	Dr.	12 over LE	NA	$275.00	**$3,300.00**
Hospitalizations **Will likely need more frequent and/or more complex hospitalizations due to need for PICC line for IV antibiotics, cardiac issues, and history of*	Dr.	5 over LE	NA	$22,540.00	**$112,700.00**

blood clots as well as potential for autonomic dysreflexia and other cardiac disorders. See below "other consideration"					
Bilateral shoulder surgery	LCP	1 each over LE	NA	$9,651.00	**$19,302.00**
Hemorrhoidectomy or similar surgery **Many options for hemorrhoid surgery as noted by Dr. and price can vary significantly, thus resulting in additional charges.*	Dr.	1 over LE	NA	$1,850.00	**$1,850.00**
					$137,152.00
Therapy and Rehabilitation:					
Perfect Step	Dr.	6 hours per week x 48 weeks per year x 3 years	NA	$95.00	**$82,080.00**
Skilled rehabilitation s/p surgeries	LCP	3 over LE	NA	$12,312.00	**$36,936.00**
Physical therapy *-usage was increased in this analysis to include update independent exercise program in addition to routine rehabilitation*	NOS/ Dr.	3 per year	27.3	$129.00	**$10,565.00**
Occupational therapy	Dr.	50 over LE	NA	$173.00	**$8,650.00**
					$138,231.00
Diagnostics:					
Imaging as specified in LCP and updated for 2018 FS	Dr. LCP	NA	NA	NA	**$35,360.00**
Laboratory as specified in LCP and updated for 2018 FS	Dr. LCP	NA	NA	NA	**$3,300.00**
					$38,660.00
Mobility:					
Seating clinic	LCP	13 over LE	NA	$149.33	**$1,941.00**
Wheelchairs and associated products as per LCP	Dr. LCP	NA	NA	NA	**$195,000.00**
Wheel chair back pack	Dr.	9 over LE	NA	$56.00	**$504.00**
Smart drive	Dr.	4 over LE	NA	$6,500.00	**$26,000.00**
Roho cushion	Dr.	9 over LE	NA	$515.00	**$4,635.00**

Misc supplies: cup holder, sipper cup, gloves, etc.	Dr.	Annual	NA	$185.00	**$5,051.00**
Exoskeleton	Dr	2 over LE	NA	$118,500.00	**$237,000.00**
Modified and accessible vehicle	Dr.	2 over LE	NA	$67,500.00	**$135,000.00**
					$605,131.00
Supplies and DME:					
DME as per LCP	Dr. LCP	NA	NA	NA	**$75,000.00**
Additional DME; rolling shower chair, grabbers, hand held shower, shower chair pad	Dr	Replace 5 over LE	NA	$936.00	**$4,680.00**
AFO, walker, forearm crutches, etc.	Mr.	Replace 5 over LE	NA	$1,500.00	**$7,500.00**
					$87,180.00
Bowel and bladder care:					
Bowel and bladder care per LCP	Dr. LCP	NA	NA	NA	**$236,596.00**
Current additional bowel and bladder supplies; protective under pads, lubricant, etc.	Mr	Yearly	27.3	$230.00	**$6,279.00**
Current additional catheter charges over initial LCP per Mr.	Mr	NA	NA	NA	**$90,000.00**
					$332,875.00
Other:					
LVN- must have skills to assist with bowel program and other services. Current rx for 16 hours per day/evening 48 weeks per year. CLT feels they could get by with 8 hours per day (336 days) **Would be reduced if Mr. requires assisted living residential care*	Dr	2688 hours per year	22	$20.00	**$1,182,720.00**
Gardener, handyman and pool	Dr.	1 per month	27.3	$100.00	**$32,760.00**
Outings	Dr. F	1 per year	27.3	$350.00	**$9,555.00**
Pool shade *Required to provide shade during pool exercises to regulate body temperature*	Dr.	4 over LE	NA	$5,000.00	**$20,000.00**

Mileage – based on LCP and new additions	LCP	NA	NA	NA	**$60,000.00**
					$1,305,035.00
Description of current medication*: **Undiscounted retail cash price. Based on current usage.*	**Recommended by**	**Frequency**	**For # of years**	**Charge per service***	**Extension over LE**
4 -Amino Pyradine 10 mg tid	Dr.	Monthly rx refill	27.3	$155.00	**$50,778.00**
Flomax (generic Tamsulosin) 0.4 mg bid	Dr	60 per month	27.3	$0.47-$2.48	**$9,238.00-$48,747.00***
Lidoderm Patch – Not using this now but is PRN Estimate 4 boxes per year	Dr	4 boxes per year (120 doses)	27.3	$3.60-$8.20	**$11,794.00-$26,863.00***
Urecholine 25 mg BID *Generic Bethanechol Chloride*	Dr.	60 per month	27.3	$0.51-$1.84	**$10,025.00-$36,167.00***
Amitriptyline 25 mg qhs	Dr. I	30 per month	27.3	$0.35-$0.58	**$3,440.00-$5,700.00***
Baclofen 10 mg tid	Dr.	90 per month	27.3	$0.24-$1.10	**$7,076.00-$32,432.00***
Gabapentin 800 mg tid	Dr.	90 per month	27.3	$0.18-$0.74	**$5,307.00-$21,818.00***
Voltaren Gel R knee, bilat shoulders, L wrist – quarterly tube	Dr.	4 tubes per year	27.3	$31.00-$60.00	**$3,385.00-$6,552.00***
Mirapex 0.125 5 tab qhs	Dr.	30 per month	27.3	$0.36-$2.04	**$3,538.00-$20,049.00***
Tadalafil 20 mg 1 po prn	Dr.	Estimate 4 per month	27.3	$26.66-$31.66	**$34,935.00-$41,487.00***
Trimethoprim sulfamethoxazole 0-1 800 mg (Bactrim)	Dr	Estimate 120 per year	27.3	.$0.48-$0.75	**$1,572.00-$2,457.00***
Famotidine – 20 mg bid	Dr.	60 per month	27.3	$0.25-$0.95	**$4,914.00-$18,673.00***
Diazepam – 5 mg (½ qhs)	Dr	15 per month	27.3	$0.14-$0.35	**$688.00-$1,720.00***
Tizanidine – 4 mg 2 tabs qid	Dr.	60 per mon	27.3	$0.24-$0.96	**$4,717.00-$18,870.00***
					$151,408.00-$332,314.00*

TOTAL PRESCRIPTION SERVICES, SUPPLIES, MEDICATIONS:					**$2,850,048.00-$3,030,954.00**

Over-the-Counter:					
Florastor 250 mg bid OTC Probiotic – mandatory due to abx sensitivity	Dr	60 per month	27.3	$0.70	**$13,759.00**
Zinc sulfate – 1 qd 220 mg o OTC	Dr.	30 per month	27.3	$0.06	**$590.00**
TheraM – 1 qd - OTC	Dr.	30 per month	27.3	$0.03	**$295.00**
Total Over-the Counter Medications:					**$14,644.00**

Other –potential additional carrier exposure: **All charges are estimated and can vary substantially. Please consult directly with Mr. ; treatment providers for more information NOS = not otherwise specified by physician*	**Recommended by**	**Frequency**	**For # of years**	**Charge per service***	**Extension over LE**
Additional ER charges for more complex admissions	NOS	Estimate 4 over LE	NA	$5,000.00	**$20,000.00**
Penile injections or other measures if medications do not work EX: Implant *These usually last 10 years so revision is included*	Dr.	2 over LE	NA	$30,000.00	**$60,000.00**
Bilateral hip replacements due to osteopenia *Need for revision would depend on activity level*	Dr. F	1 each hip over LE	NA	$45,000.00	**$90,000.00**
Bilateral knee replacements due to osteopenia and injury *Need for revision would depend on activity level*	Dr.	1 each knee over LE	NA	$38,000.00	**$76,000.00**
Respite care for Ms. *8 hours per day for 2 weeks per year*	NOS	112 hours per year	22	$20.00	**$49,280.00**
LTC – residential living	NOS	Full time	Estimate 5 years (60 months)	$4,000.00-$6,600.00 per month	**$240,000.00-$396,000.00**
Hardware removal wrist	NOS	1	NA	$9,000.00	**$9,000.00**
Hardware removal left leg	NOS	1	NA	$9,000.00	**$9,000.00**
Additional hospitalizations/ critical care for more complex	NOS	Estimate 4 over LE	NA	$50,000.00	**$200,000.00**

situations such as autonomic dysreflexia episodes					
Flagyl to prevent c-dif infections **Can occur with antibiotic use CLT is also taking probiotics and other medications noted above to combat c-dif*	Dr.	Estimate 1 round per year	27.3	$13.35	**$364.00**
Driving evaluation - update	Dr.	1	NA	$1,750.00	**$1,750.00**
Driving assessment / PTSD	NOS	Estimate 10 sessions	NA	$250.00	**$2,500.00**
Cardiac testing prn	NOS	TBD	NA	$5,000.00	**$5,000.00**
Total:					**$762,894.00-$918,894.00**

Total all items and services:					**$3,627,586.00-$3,964,492.00**

Other considerations for settlement:					
COLA					**TBD**
Medical Custodial Account Admin Fees					
Local, state, and delivery charges for medications and supplies					**TBD**
Other:					**TBD**
Total:					**TBD**

It is not possible to predict all possible future care that may be needed or calculate the actual charges for future medical procedures with precision. Fee Schedules are used to re-price charges after services have been rendered. All charges are estimates and assume no complications unless specified. Previous and current medical bills are not an accurate prediction of future medical charges, as the carriers often negotiate substantial discounts not applicable post settlement. It is strongly recommended that all future care recommendations be identified or confirmed by the Applicant's treating physicians prior to settlement.

The amount estimated/charged can fluctuate significantly due to, but not limited to, variations in coding and billing procedures, co-morbidity, complexity of case, fee schedules, negotiated service contracts, location of facility, and patient population categories. Medical Settlement Specialists, LLC reports should only be used as a negotiation resource in conjunction with your legal experience with workers' compensation cases as well as the specific case facts as a whole. By using information contained in this report, you agree and acknowledge Medical Settlement Specialists, LLC, shall not be held liable for errors, inaccuracies, omissions, or other defects regardless of the cause, for reasons cited herein. The information contained in this analysis are estimates and are based on information from professional third party databases and sources accessed by Medical Settlement Specialists, LLC.

Information regarding surgical and other procedures are based on medical information that is claim-specific. Treatment may involve multiple procedure codes/charges which can only be determined at the time of service by sources such as a medical provider, pathology, laboratory, anesthesiology, radiology, facility, etc. Surgery charges cited herein include estimated charges for the global surgical period, surgeon fees, applicable assistant fees, anesthesia, facility charges, pre-operative clearance, post-operative rehabilitation, and post-operative supplies and medications.

Medications are priced as currently dispensed and it is anticipated that medications may need to be adjusted over time. All therapy, massage, osteopathic, and chiropractic charges are estimated at an average rate for typically prescribed treatment unless treatment modalities are specified separately. As medical science is continually advancing, there may be alternative medical procedures available in the future or services that incur additional costs that are unforeseeable at this time. Cost of living and medical inflation adjustments may apply. State, local, and delivery charges are not included and may apply. CPT codes are a copyright of the AMA.

PROFESSIONAL ADMINISTRATION

Professional Administration of the MSA account has been around since the early 2000's

Basically – The Professional administrator is an independent 3rd party that helps the injured worker manage their Medicare Set-Aside and other medical costs after settlement.

Like many other elements involved in the settlement of the Comp Case – things have changed and evolved

Professional admin is no different; this product and service is different now - so let's take a quick look

When we think back – it was offered to help the settling injured worker who were catastrophically injured manage their care when they were unable to do so. Also – they came into existence to assist help with the complex reporting requirements of the Govt for the set-aside accounts. It was utilized by individuals who wanted to ensure that they were complying with the federal govt to ensure that they would have their Medicare entitlement preserved for the rest of their lives. And that is still true today.

Back in the day the pricing was rather steep – there was a set up fee of a couple to $3,000 – and then there were lifetime annual payments attached to that as well. I remember that professional admin could cost as much as $20,000 - $40,000 and more. This definitely prevented smaller settlements from even being considered for professional administration.

We now have seen the pricing evolve into a one time REASONABLE fee – and there are many circumstances where the Carrier is willing to pay that charge. The Professional admin companies now receive money on the back end of the settlement primarily from the Pharmaceutical Companies – so the savings was passed to the injured worker.

The mechanics of how it works is as follows:

The MSA money is given to the Professional Admin company – they establish a bank account for the injured party's future medical care – then act as custodian

They receive bills and pay them on behalf of the injured worker

And they handle all required annual reporting for the Medicare Set-Asides.

So with the pricing now lower – there is a greater opportunity to have professional administration available for many many more cases.

PROFESSIONAL ADMINISTRATION IS AVAILABLE TO EITHER PARTY

WE HAVE SEEN THE DEFENSE BECOME VERY PROACTIVE IN OFFERING PROFESSIONAL ADMINISTRATION. LETS LOOK AT WHY

THE CARRIERS, AS WE DISCUSSED, HAVE BEEN USING THESE COST CONTAINMENT MEASURES TO KEEP THE MSA SMALL. AS A RESULT – THEY ARE OFFERING MONEY TO SETTLE THE COMP CASE AND THEN NEEDED A WAY TO TRY AND DEMONSTRATE THAT THE MONEY IN THE MSA IS ADEQUATE TO HANDLE THE FUTURE MEDICAL NEEDS OF THE INJURED WORKER.

WHAT THE CARRIER SEES IS;

INJUREED WORKER WORRIED THAT SETTLEMENT AND NAMELY THE MSA IS TOO LITTLE TO COVER FUTURE COSTS

THEY (THE APPLICANTS) ARE DEFINITELY FRUSTRATED WITH UR/IMR

THE INJURED WORKER IS RELUCTANT TO HANDLE THEIR OWN FUTURE MEDICAL CARE – TOO MUCH TO DEAL WITH

AND THE INJURED WORKER CANNOT HANDLE THE REPORTING OF THE MSA EXPENDITURES TO CMS.

SO YOU HAD THE CARRIERS REACHING OUT TO THE ADMIN COMPANIES – UTILIZING THEM TO DEMONSTRATE THAT THE MONEY BEING OFFERED WAS SUFFICIENT TO COVER FUTURE NEEDS.

YOU KNOW THIS IS WHERE IT GETS INTERESTING AND IMPORTANT

The MSA is prepared by utilizing pricing from CALIFORNIA WORK COMP FEE SCHEDULE. CMS WANTS THIS PRICING FOLLOWED BY DR.; PROVIDERS; AND THE INJURED WORKER – BUT THERE IS NO ENFORCEMENT MECHANISM – CMS CANNOT FORCE ANY PHYSICIAN TO TAKE FEE SCHEDULE AND AS A RESULT – HEALTH CARE PROVIDERS ARE BILLING USUAL AND CUSTOMARY.

So the situation is – Applicant settles their case with a MSA on the "lower side"

Now they are immediately left on their own to deal with Health Care Providers who will be billing at their normal rates. You have injured workers that don't really know this – don't know that they can negotiate the bills and don't have access to any fee schedules to work to keep their bills lower.

SO I HEAR FROM APPLICANT'S ATTORNEYS AND OTHERS – "WHAT DOES IT MATTER? – MEDICARE WILL STEP IN"

Well it does matter – as soon as THE APPLICANT depletes the MSA money and end up with Medicare you are now subjected to the out of pocket expenses – CO-PAY, DONUT HOLE AND 20% MEDICARE DOES NOT PAY ON PART B MEDICARE

OUT OF POCKET EXPENSES

THIS IS SORT OF A LOSE LOSE SITUATION ALL AROUND

2

LOSE -LOSE

FOR MEDICARE THE INJURED WORKER IS BECOMING THEIR RESPONSIBILITY BECAUSE THE MSA FUNDS WERE INADEQUATE AND THE INJURED WORKER NOW WILL HAVE OUT OF POCKET EXPENSES

THIS IS ONE OF THE REASONS WE HAVE SEEN CMS RECOMMENDING THE USE OF PROFESSIONAL ADMINISTRATION COMPANIES

THE PROFESSIONAL ADMIN COMPANIES HAVE FEE SCHEDULE INFO AND UNDERSTAND HOW TO UTILZIE THE ICD CODES TO TRY TO PREVENT OVER BILLING ETC FROM PROVIDERS AND THEY ALSO HAVE GREATER PURCHASING POWER BECAUSE OF THE VOLUME OF ITS MEMBERS AND THEY HAVE THEIR OWN NETWORK OF PROVIDERS (WHICH IS OPTIONAL)

INJURED WORKER CAN ALSO BENEFIT ON SAVINGS INVOLVING THEIR NON-MEDICARE MEDICAL NEEDS

SO WHY IS EVERYONE NOT RUNNING TO UTILIZE PROFESSIONAL ADMINISTRATION???

Well you see what I see

At the time of a settlement – emotions are running high, many injured workers have a strong reaction - not wanting professional administration. You hear it - NOBODY IS GOING TO TOUCH MY MONEY – UNDERSTANDABLE – FOR CASES THAT Have gone on for years AND – SETTLEMENT IS LESS THAN THEY EXPECTED.

Professional Administration services of Bill Review and the cost savings provided from that are what can help stretch the money that was accepted – however in a knee jerk reaction they refuse.

Now what I hear anecdotally – is that 4-6 months after settlement injured worker needs assistance in locating doctors, or are facing new medical procedures and have no idea as to cost or who to turn to, or new prescriptions are being offered -- THE PROFESSIONAL ADMINISTRATION COMPANY CAN HELP THEM WITH THESE ISSUES THAT THEY COULD NOT FORSEE WHEN THE CASE SETTLED

WHAT I HAVE FOUND IS THAT THERE IS A PRODUCT IN THE MARKET PLACE THAT SEEMS TO ADDRESS THE MAJOR CONCERNS OF THE INJURED WORKER AND ALLOWS THEM TO TAKE ADVANTAGE OF THE MANAGEMENT AND COST SAVINGS COMPONENTS OF PROFESSIONAL ADMINISTRATION WITHOUT HAVING TO PART WITH THEIR MONEY. AMETROS HAS A PRODUCT AMETHYST THAT ALLOWS FOR THE MONEY TO REMAIN IN THE INJURED WORKERS BANK ACCOUNT WHILE BEING ABLE TO HAVE AMETROS PROVIDE THEM WITH THE NECESSARY INFO TO COMPLY WITH THE CMS RULES AND PROVIDE SOME ASSISTANCE IN THE ANNUAL REPORTING ETC.

ADDITIONALLY THIS SAME COMPANY – AMETROS WILL ALLOW ANY "MEMBER" TO CLOSE THEIR PROFESSIONAL ADMIN ACCOUNT IF THEY ARE NOT HAPPY WITH THE SERVICE – SEEMS LIKE A SITUATION THAT ALSO CAN PROVIDE THE BEST OF BOTH WORLDS.

3

I BELIEVE THAT WE HAVE COMPANIES NOW IN THE MARKET PLACE THAT CAN PROVIDE THE SAME COST SAVING OPPORTUNITIES THAT THE COMP CARRIERS ARE UTILIZING – THE BILL REVIEW AND MANAGEMENT OVERSIGHT.

THESE COMPANIES SHOULD AND CAN PROVIDE YOU WITH HOW MUCH PRESCRIPTIONS, TREATMENTS AND EQUIPMENT WILL COST ON THEIR PLATFORM. THIS IS AN EXCELLENT WAY TO DETERMINE IF THE ADMINISTRATOR CAN PROVIDE THE DISCOUNTS AND SAVINGS THAT WILL ALLOW THE INJURED WORKER TO SETTLE THEIR CASE WITH THE DOLLARS BEING OFFERED BY THE CARRIER.

IT SEEMS THAT THE INJURED WORKER HAVING AN ALLY AND ADVOCATE TO HELP THEM MANUVER THROUGH THE MAZE WE CALL HEALTH CARE IS A VERY VALUABLE TOOL FOR ANYONE INTERESTED IN SETTLEMENT.

I BELIEVE THAT THE BILL REVIEW CAPABILITIES OF THIS SERVICE ARE PRETTY AMAZING FOR – FOR AN INDIVIDUAL TO TAKE ADVANTAGE OF (SEE PAGE # 912-915) FOR EXAMPLES OF THIS COMPONENT OF THE PROGRAM

ONE LAST ISSUE TO COVER – AND THIS ISSUE HAS BEEN PRESENT SINCE DAY ONE – WHICH IS – WHAT IS MEDICARE DOING? WHAT DO THEY KNOW? WHAT ARE THEIR PLANS FOR THE FUTURE

(SEE PAGE # 907) I WORK TO STAY IN TOUCH WITH PROFESSIONAL ADMIN VENDORS ON THIS ISSUE

YOU CAN SEE THAT MEDICARE IS IN TOUCH WITH THE PROFESSIONAL ADMIN FOLKS. CMS IS DEFINITLEY LOOKING AT EARLY EXHAUSTION OF THE MSA FUNDS – ON LUMP SUM EXHAUSTION 100% OF THE TIME MEDICARE IS CALLING TO ASK QUESTIONS – WITH STRUCTURED SETTLEMENTS IT IS LESS.

IN MY DISCUSSIONS WITH THESE VENDORS – IT IS CLEAR THEY KNOW WHAT IS GOING ON BUT STILL NOT SO CLEAR AS THEIR FUTURE ACTIONS – WHAT I AM TOLD IS THAT ON MEDICARE ADVANTAGE PLANS – THOSE ADMINISTRATORS ARE BEING MORE AGGRESSIVE IN WORKING TO HAVE THE MSA FUNDS UTILIZED.

*** I AM SITTING HERE WITH A MEDICARE DENIAL LETTER I JUST WAS PROVIDED A FEW DAYS AGO. BASICALLY – THE CLAIM IS BEING DENIED BY MEDICARE AND THE FOOTNOTE AS TO THE EXPLANATION READS: SEE ATTACHMENT

What about Reversion

4

Double the Ongoing Medical Treatment You Get from Your Injury Settlement

Injured individuals across the country are settling claims against their employer or a third party every day and often they have no idea how much a professional administrator could help maximize the money they receive for their ongoing medical care.

Professional administrators establish a bank account for the injured party's medical settlement funds and then pay for all of their healthcare needs on their behalf, but at ***significant discounts***. The best administrators, leverage their scale to save the injured individual substantial sums of money on every healthcare bill. The discounts they can command can sometimes be up to 90% of what the billed cost was for the treatment!

Using an administrator to secure discounts can make the settlement funds last much longer and allows the injured party to potentially get double, sometimes triple or more medical treatment from their settlement funds.

In the past, professional administrators have traditionally been thought of to help catastrophically injured individuals manage their care when they are incapable. Administrators have also been thought of to help with complex reporting requirements from the government for Medicare Set Aside accounts. These two uses of the service are still relevant, but for most injured individuals and their attorneys, the most powerful benefit that administrators bring to the table are their discounts, saving money for the injured party on medical bills. Let's take a look at three examples of how this happens*:

1. *When an injured individual, Beth, settled her case and then needed a spinal cord stimulator implanted a year later, she faced some extremely daunting bills. Here is a link to a real bill that she received with detail on how it was reduced. [IMAGE OF BILL]*

   *Because Beth had Ametros as her professional administrator, the original billed amount of $132,777 for the procedure was reduced to $47,551! That is a **savings of over $80,000**!*

   In this case, much of the savings comes from Ametros reducing the bill to appropriate fee schedule amount because her account was a Workers' Compensation Medicare Set Aside (MSA).

   The money saved by the administrator stays in Beth's account for her future healthcare needs. Beth now has more existing funds should she need another operation down the road.

2. *Roger settled his case in 2013 and recently needed a procedure done to replace his catheter implant and graft some tissue. The sticker price billed to him was $15,359 and after review by Ametros, his bill was reduced to $1,886 for a savings of about $13,500! For this procedure, Ametros was able to save Roger about **87% off the original billed charge.***

   The reduction is mostly due to the fee schedule that otherwise would have gone unseen if Ametros and did not take the steps to review the bill. Similar to Beth's case, Ametros was able to save Roger quite a bit by using the workers' compensation fee schedule because Roger had an MSA. To view the full bill and reduction, click here. [IMAGE OF BILL]

3. *Discounts for medical costs do not just apply to individuals that have settled with an MSA. Take Josefina for example. She settled her third party liability case and then two years later needed an*

X-Ray of her ankle for an unexpected complication. Ametros received the bill on her behalf and reduced the charge from the original total price of $529.00 to just $201.83. In this situation, Ametros leveraged its facility network to save $327.17 for Josefina.

*View the full bill **here.** [IMAGE OF BILL]*

Would you hire a contractor to work on your home with no cost estimate? It's easy to take steps to find out the amount of savings the administrator can provide on medical costs for your case.

When you are assessing if a professional administrator is a good fit, you should ask them for a cost estimate: how much prescriptions, treatments and equipment will cost on their platform. Most will provide it for free. By doing this, you can easily determine lifetime costs and find the company that offers the biggest discounts and highest savings. The right administrator may save you tens or hundreds of thousands of dollars more over your lifetime!

If you are involved in settling a case where the injured party will have future medical costs, think twice about their going it alone and paying the sticker price for future medical costs. In fact, that approach can be very costly. Having an administrator can be a powerful ally and advocate for the individual after settlement. To find out more about administration and potentially how much you could save, contact Ametros today.

**The medical bill examples shown are real bills with real discounts provided. The names of the clients and their personal identifying information has been redacted for privacy.*

LATINO COMP

8th Annual Golf Tournament

Friday, April 26, 2019

10:30am Registration   12:00pm Shotgun Start

Lunch 11am sponsored by *Matrix Document Imaging*

Rio Hondo Golf Course

10627 Old River School Rd, Downey, CA 90241

Sponsorship Levels

❑ **Gold $2500**

- One foursome
- (4) Extra Award Banquet Tickets
- Tee Table at Hole
- Tee Sign
- Marketing Table at Banquet
- Full Page Ad in Program
- Prominent Recognition Year Round

❑ **Silver $2000**

- One Foursome
- (2) Extra Award Banquet Tickets
- Tee Table at Hole
- Tee Sign
- Half Page Ad in Program
- Year Round Recognition

❑ **Bronze Sponsor $1500**

- One Foursome
- Tee Sign
- Quarter Page Ad in Program
- Year Round Recognition

❑ **Hole (Tee Table) Sponsor**
***$400 early bird**
$500 after April 1, 2019

- Tee Sign
- Company Name in Program
- Year Round Recognition

❑ **Tee Sign Sponsor $150**

- Tee Sign
- Company Name in Program

❑ **Marketing & Advertisements Only**

- $3000 Golf Shirt (limited to 2 sponsor logos / call for details)
- $250 Full Page Ad in Program
- $150 Half Page in Program
- $50 Business Card in Program

Registration

Early Bird Prices
❑ $800 Foursome
❑ $200 Individuals
❑ $60 Banquet Only

Prices
❑ $900 Foursome
❑ $250 Individuals
❑ $70 Banquet Only

Full payment for EARLY BIRD must be received by **Monday, April 1, 2019**

Golf fee includes green fee, golf cart, shirt, goodie bag, foursome picture, awards banquet buffet with cash bar, raffle, prizes, music and entertainment

For Sponsorship information and RSVP, please contact
Isabel Pires (916) 267-1129 / Fax (323) 927-1973
Email admin@latinocomp.org

*Please submit artwork & foursome names by 4/15/19 to admin@latinocomp.org

Name: ____________________
Company: ____________________
Address: ____________________
Ph: ____________ Email: ____________

Foursome
Team Name: ____________________
Player 1) ____________________
Player 2) ____________________
Player 3) ____________________
Player 4) ____________________

Payment
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