

WORKERS' COMPENSATION LIEN CLAIMANT COLLECTIONS NEWSLETTER

RECENT FIRST APPELLATE DISTRICT: ON MANDATORY UTILIZATION REVIEW

In *State Comp. Ins. Fund v. Workers' Comp. Appeals Bd.* (2008) 44 Cal.4th 230, 233-234 (*State Comp.*), our Supreme Court clarified that when an employer is faced with deciding whether to approve or deny the treatment recommendation of an injured worker's physician, it *must* conduct utilization review pursuant to Labor Code section 4610. By the same token the employer *cannot*, as an alternative to utilization review, dispute the treatment request under the general dispute resolution framework set forth in section 4062, subdivision (a) (section 4062(a))

Section 4062(a) specifically provides that *employer objections* to a treating physician's recommendation for spinal surgery, after denial of the physician's recommendation pursuant to the utilization review procedures detailed in section 4610, *shall be subject to section 4062(b)*. In line with this provision, section 4610(g)(3)(A) also states: "If a request to perform spinal surgery is denied, *disputes shall be resolved in accordance with subdivision (b) of Section 4062.*" (Italics added.)

Section 4062(b) in turn states that "[t]he *employer* may object to a report of the treating physician recommending that spinal surgery be performed within 10 days of the receipt of the report." (Italics added.) Where, as here, the employee is unrepresented at that time, the statute calls for the administrative director to randomly select a surgeon "to prepare a second opinion report resolving the disputed surgical recommendation." (*Ibid.*) The evaluation occurs on an accelerated basis, with the second opinion report to be served within 45 days of the original surgical request. (*Ibid.*) Moreover, the second opinion physician must be a "licensed board-certified or board-eligible orthopedic surgeon or neurosurgeon . . ." (*Ibid.*)

Finally, *Cervantes* clarifies that the employer must both complete its own utilization review and make its section 4062(b) objection within 10 days of receiving the treating physician's report recommending spinal surgery. (*Cervantes, supra*, 74 Cal.Comp.Cases at pp. 1351-1352.) First, section 4062(b) requires the employer to object to the spinal surgery

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recommendation within 10 days of receiving the report. Second, section 4062(a) states that these employer objections are "subject to subdivision (b), and after denial of the physician's recommendation, in accordance with Section 4610." (Italics added.) In sync, section 4610(g)(3)(A) provides that if utilization review *denies* the spinal surgery request, disputes shall be resolved in accord with section 4062(b). These three statutory provisions, taken together, make it clear that the spinal surgery second opinion process commences *after* utilization review has denied the requested spinal surgery. The utilization review scheme does not mandate a 10-day turnaround time, but 10 days is consistent with the requirement that "[p]rospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician." (§ 4610, subd. (g)(1).)

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CERTIFIED FOR PUBLICATION

IN THE COURT OF APPEAL OF THE
STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

DIVISION FOUR

IN THE NEWS AT:

WWW.WORKCOMPLIENS.COM

[February 19, 2010:](#) Insurance Commissioner Poizner Announces Two San Diego Men Plead No Contest in Workers' Compensation Fraud Cases Duo Agree to Forgo \$60 Million in Medical Liens and Bills Pending at WCAB

[February 17, 2010:](#) California Insurance Commissioner Steve Poizner today announced that Richard Lewis Johnson, 49, of City of Commerce pled no contest Feb. 4 to one count of grand theft of workers' compensation payments and was placed on three years probation and ordered to pay \$20,714 in restitution to Avizent Risk Management.

[February 16, 2010:](#) The Division of Workers' Compensation has successfully processed one million document batches into the Electronic Adjudication Management System (EAMS), achieving this milestone in less than a year and a half since the case management system was activated.

[February 11, 2010:](#) ROOFING CONTRACTOR CONVICTED IN CALIFORNIA'S LARGEST PREMIUM INSURANCE FRAUD SCAM

[February 11, 2010:](#) SELF-PROCLAIMED NATURAL DOCTOR SENTENCED FOR TREATING CANCER PATIENTS WITHOUT A LICENSE AND PRACTICING MEDICINE WHILE RUNNING ILLEGAL HMO

[February 08, 2010:](#) As part of its strategy to increase access to the Electronic Adjudication Management System (EAMS), the Division of Workers' Compensation today began work with external partners on a plan that will allow bulk filing of selected documents by the end of the year.

[FEBRUARY 05, 2010:](#) FEBRUARY COLLECTION NEWSLETTER

VICKIE ELLIOTT,
Petitioner,
v.
WORKERS' COMPENSATION A
NEWSGROUP OF SACRAMENT
Respondents.

In *State Comp. Ins. Fund v. Workers' Comp. Appeals Bd.* (2008) 44 Cal.4th 230, 233-234 (*State Comp.*), our Supreme Court clarified that when an employer is faced with deciding whether to approve or deny the treatment recommendation of an injured worker's physician, it *must* conduct utilization review pursuant to Labor Code¹ section 4610. By the same token the employer *cannot*, as an alternative to utilization review, dispute the treatment request under the general dispute resolution framework set forth in section 4062, subdivision (a) (section 4062(a)).

In this case we are asked to clarify the dispute resolution procedure that comes into play when the employee's treating physician specifically recommends *spinal surgery* but the employer's utilization review decision is to deny treatment. As we explain, special procedures and timeframes govern this situation calling for the *employer* to instigate the spinal surgery second opinion process detailed in section 4062, subdivision (b) (section 4062(b)); however, they were not followed in this case. Instead, the Workers' Compensation Appeals Board (WCAB or board) ruled that under *Brasher v. Nationwide Studio Fund* (2006) 71 Cal.Comp.Cases 1282 (*Brasher*), when an employer responds to a treating physician's recommendation for spinal surgery by timely denying that request pursuant to its utilization review, the *employee* must object to the denial and the dispute will then be resolved under section 4062(b). Because petitioner Vickie Elliott did not object to the utilization review denial or seek a spinal surgery second opinion report, the board decided her employer was not obligated to provide the requested spinal

surgery. After this matter became fully briefed, the WCAB issued its en banc decision in *Cervantes v. El Aguila Food Products, Inc.* (2009) 74 Cal.Comp.Cases 1336 (*Cervantes*), explicitly denouncing the *Brasher* holding relied on by the WCAB in this case. We, too, reject that holding, reverse the decision of the WCAB, and remand with directions that the board immediately order respondents¹ to authorize the requested spinal surgery or object to the treating physician's spinal surgery recommendation under section 4062(b) within 10 days of receipt of the order, thereby commencing the spinal surgery second opinion process.

BACKGROUND

The facts are not in dispute. In June 2005, Vickie Elliott was employed as a working merchandiser supervisor for The Newsgroup. While stocking and moving merchandise, stacked totes of magazines fell on Elliott. Her primary treating physician referred Elliott to Dr. Robert Rovner, a spine surgeon, who recommended spinal surgery on May 20, 2008. The faxed documents were received by Gallagher Bassett, The Newsgroup's workers' compensation claims administrator, on May 21, 2008. Gallagher Bassett submitted the request through the "Utilization Review process." By a document dated May 29, 2008, Dr. Kelly Agnew issued an opinion denying the requested lumbar fusion.

At the time of the denial, Elliott was not represented by an attorney. No one notified Elliott of any requirement to request a spinal surgery second opinion or file an objection to the utilization review denial. Nor did The Newsgroup submit a request for a second spinal surgery opinion. Dr. Rovner appealed the denial and on August 1, 2008, a different doctor issued a second utilization review denial. Elliott retained counsel at the end of August 2008. Counsel demanded that respondents immediately authorize the proposed spinal surgery, asserting that the denial was

untimely and invalid. Further correspondence delved into the requirements governing spinal surgery recommendations. In January 2009 counsel filed a declaration of readiness to proceed to an expedited hearing. The workers' compensation judge found that the utilization review denial was timely; respondents did not seek a spinal surgery second opinion after the utilization review denial as required by sections 4062(b) and 4610, subdivision (g)(3)(A) (section 4610(g)(3)(A)); respondents did not notify Elliott of any requirement to file a written objection to the utilization review denial within 10 days of that denial; and more than 45 days passed since the original request for spinal surgery. Accordingly, the workers' compensation judge ordered respondents to authorize the requested spinal surgery "forthwith." Respondents petitioned for reconsideration, arguing that they properly denied Elliott's request for spinal surgery following the utilization review, in keeping with *State Comp.* and the procedures set forth in the significant panel decision¹ in *Brasher*. Under respondents' view, an employer is entitled to rely and rest upon its utilization review denial of the request for spinal surgery. Therefore, the onus is on the *employee* to commence the process for procuring a second spinal surgery opinion under section 4062(b). Elliott countered that under *State Comp.*, the procedures set forth in *Brasher* are no longer valid. Further, sections 4610 and 4062 mandate that it is the *employer* who must request a second opinion following denial pursuant to the utilization review. The WCAB agreed with respondents, granted reconsideration and rescinded the workers' compensation judge's order directing respondents to authorize the spinal surgery. This petition for writ of review followed.

DISCUSSION

Introduction; *State Comp. Decision*
Reacting to escalating workers' compensation costs, the

Legislature passed Senate Bill No. 228, effective January 1, 2004. (2003-2004 Reg. Sess.) This legislation enacted omnibus reform of the workers' compensation scheme. Pertinent here are (1) the statutory utilization review process set forth in section 4610,¹ and (2) specific procedures for resolving disputes about spinal surgery requests, featured in section 4062(b). The following year, Senate Bill No. 899, passed as urgency legislation, continued the reforms. Among many other things, this bill changed the general dispute resolution process set forth in section 4062(a). Examining legislative intent spurring these reforms, the *State Comp.* court explained that the new utilization review structure created by the Legislature balances the twin interests of speed and accuracy. While the system emphasizes quick resolution of treatment requests, it allows employers to pursue additional time if more information is needed to make a decision; and, significantly, medical review is *required* before a utilization review doctor can modify, delay or deny a treatment request. (*State Comp., supra*, 44 Cal.4th at pp. 241, 243-244, citing section 4610, subs. (e), (g)(1), (5).)

Specifically, section 4610 requires *every* employer to establish a complying utilization review process governed by written policies and procedures ensuring that decisions about proposed medical treatment services are consistent with specific, approved treatment standards, guidelines and schedules. (§§ 4600, 4610, subs. (b), (c).) Further, the statute mandates that only *licensed physicians* who are competent to evaluate the particular clinical issues involved can modify, delay or deny requests for treatment. (§ 4610, subd. (e).) As well, treatment decisions must be made expeditiously, not to exceed five working days from the date of receipt of information "reasonably necessary" to make the decision, but in any event no later than 14 days from the date

of the treatment request. (*Id.*, subd. (g)(1).)¹ However, if the employer does not have all the information reasonably necessary and requested, or requires expert consultation, or has asked for an additional examination that is reasonable and consistent with sound medical practice, the employer must immediately notify the physician and employee and specify an anticipated date of receipt. Upon such receipt, the employer shall approve, modify or deny the authorization. (*Id.*, subd. (g)(5).) Where the request is not approved in full, disputes are resolved in accord with section 4062. (§ 4610(g)(3)(A).) However, if a request to perform spinal surgery is denied, disputes are resolved in accord with section 4062(b). (§ 4610(g)(3)(A).) The *State Comp.* court concluded, in light of the comprehensive nature of section 4610 and the goals of controlling costs while ensuring workers' access to prompt, quality, standardized care, that the Legislature intended for employers to use the statutory utilization review process "to review and resolve *any and all requests* for treatment . . ." (*State Comp.*, *supra*, 44 Cal.4th at p. 237, italics added.) Thus, an employer may not elect to bypass utilization review and instead invoke the section 4062(a) provisions to dispute an employee's treatment request. (*State Comp.*, *supra*, at p. 237.) This is so because the section 4062(a) dispute procedure is not available to employers to object to a treating physician's medical determination concerning medical issues "subject to Section 4610." (§ 4062(a).) On the other hand, the same statute *allows employees* to invoke section 4062(a) to resolve disputes concerning an *employer's* section 4610 utilization review decision to modify, delay or deny a treatment recommendation. In her concurring opinion, Justice Kennard made it clear that sections 4610 and 4062 establish a two-step process for settling medical treatment disputes. Utilization review is a threshold procedure governing the

employer's evaluation of whether to approve or deny the treating physician's recommendation. (*State Comp.*, *supra*, 44 Cal.4th at pp. 245-246 (conc. opn. of Kennard, J.)) Because any decision to delay, modify or deny a treatment request must be consistent with detailed treatment guidelines, that decision must be made by a qualified licensed physician. (§ 4610, subd. (e).) A dispute does not legally arise unless the employer prompts the utilization review in a timely fashion. Where that process leads to a modification, delay or denial of the requested treatment, the employee is the aggrieved party. In all cases except those recommending spinal surgery, the employee may invoke the section 4062(a) dispute resolution mechanism. (§§ 4062(a), 4610(g)(3)(A); see *State Comp.*, *supra*, 44 Cal.4th at p. 246 (conc. opn. of Kennard, J.))

Spinal Surgery Requests

The step one utilization review process is the same for all treatment requests, including those for spinal surgery. However, the Legislature has devised a separate, fast-track method for determining spinal surgery disputes in the face of a utilization review denial of a request for spinal surgery. In a nutshell, utilization review denials for spinal surgery trigger an expedited second opinion process which itself is triggered by the employer's post-utilization review *objection* to the treating physician's recommendation. Section 4062(a) specifically provides that *employer objections* to a treating physician's recommendation for spinal surgery, after denial of the physician's recommendation pursuant to the utilization review procedures detailed in section 4610, *shall be subject to section 4062(b)*. In line with this provision, section 4610(g)(3)(A) also states: "If a request to perform spinal surgery is denied, *disputes shall be resolved in accordance with subdivision (b) of Section 4062.*" (Italics added.)

Section 4062(b) in turn states that "[t]he *employer* may object to a report of the treating physician recommending that spinal surgery be performed within 10 days of the receipt of the report." (Italics added.) Where, as here, the employee is unrepresented at that time, the statute calls for the administrative director¹ to randomly select a surgeon "to prepare a second opinion report resolving the disputed surgical recommendation." (*Ibid.*) The evaluation occurs on an accelerated basis, with the second opinion report to be served within 45 days of the original surgical request. (*Ibid.*) Moreover, the second opinion physician must be a "licensed board-certified or board-eligible orthopedic surgeon or neurosurgeon . . ." (*Ibid.*) Under the governing regulations, the employer's objection to the treating physician's recommendation for spinal surgery must be served on the administrative director and lodged on the prescribed "DWC Form 233" which, not surprisingly, is designed only for completion and submission by the employer. (Cal. Code Regs., tit. 8, §§ 9788.1, 9788.11.)

Analysis

Disregarding the plain language of the above statutes, the WCAB in the present case ruled that if the request for spinal surgery is denied under the utilization review process, it is the *employee's* obligation to seek a spinal surgery second opinion report under section 4062(b), citing *Brasher*. *Brasher*, a pre-*State Comp.* decision, held that in response to a treating physician's spinal surgery recommendation, an employer has four options: (1) authorize the surgery; (2) object pursuant to section 4062(b) by filing a DWC Form 233 within 10 days of receipt of the recommendation; (3) submit the recommendation to utilization review; or (4) pursue both options (2) and (3), either simultaneously or by filing an objection after a utilization review denial, meeting the deadlines for each process. (*Brasher*, *supra*, 71 Cal.Comp.Cases at p. 1282.) The WCAB in *Brasher* further concluded the *if* the employer conducts the utilization review and the recommended surgery is

denied, it is then incumbent *on the employee* to object *under section 4062(a)*¹ if the employee still wants the surgery. (*Brasher*, *supra*, 71 Cal.Comp.Cases at p. 1287.) Section 4062(a) ordinarily would give the employee 20 days to notify the employer of his or her objection to an unfavorable utilization review decision. However, section 4610(g)(3)(A) directs that disputes over denials of spinal surgery shall be resolved under section 4062(b), which only dictates a procedure for *employers* to object, which objection must be commenced within 10, not 20 days. Given the specificity of the expedited procedures for spinal surgery, and acknowledging that it carved out an employee objection responsibility through a "convoluted" system that started the employee on a section 4062(a) track and then switched over to the section 4062(b) track, the *Brasher* panel concluded that the employee would have to object to a utilization review denial within 10 days from receipt of the denial, rather than the general 20-day timeframe set forth in section 4062(a). (*Brasher*, *supra*, 71 Cal.Comp.Cases at pp. 1287-1288.)

The *Brasher* panel improperly distorted sections 4062 and 4610 to legislate an employee duty that was nowhere to be found in the statutory scheme. The statutes and regulations make it abundantly apparent that where there is a dispute about the treating physician's recommendation for spinal surgery, it is the employer, not the employee, who must initiate the request for a second spinal surgery opinion.

Contrary to the process created by the *Brasher* panel, objections to a treating physician's recommendation for spinal surgery are pursued by the employer in the following manner: When an employee's treating physician recommends spinal surgery, the employer must channel that request through its utilization review process. During that process a physician, contracted by the employer or its insurer, evaluates the treatment request. If the physician decides to deny the

request, a dispute arises which must be resolved in accordance with section 4062(b). That statute and the governing regulations require the employer to object to the treating physician's recommendation within 10 days of receipt of the request, in compliance with sections 9788.1 and 9788.11 of California Code of Regulations, title 8. At no point does this scheme place the onus on the employee to initiate the second spinal surgery report.

We further point out that as a matter of statutory construction, a specific provision relating to a particular subject will govern that subject as against a general provision. (Code Civ. Proc., § 1859; *Miller v. Superior Court* (1999) 21 Cal.4th 883, 895.) While section 4062(a) states the general rule for employee objections to utilization review decisions that modify, delay or deny a treatment recommendation, the language of section 4062(a) and (b) and section 4610(g)(3)(A) carves out a specific rule for spinal surgery cases calling for a post-utilization review *employer objection* to the treating physician's recommendation. It makes sense that the legislative reforms impose the duty to institute the spinal surgery second opinion procedure on the employer: The employer is in the best position to inform the worker of his or her rights as well as to implement the second opinion process with the administrative director within the expeditious timeframes outlined in the statutory scheme.

On November 19, 2009, the WCAB issued its en banc decision in *Cervantes*, explicitly rejecting the *Brasher* rule that, when an employer denies spinal surgery, the *employee* must timely object under section 4062(a), and thereafter is

"switched over to the section 4062(b) track." (*Cervantes*, *supra*, 74 Cal.Comp.Cases at p. 1350 & fn. 13.) Pointedly, the *Cervantes* court acknowledges that in the present case, the WCAB panel had followed the repudiated *Brasher* holding which the entire board, including the panelists deciding Elliott's case, now rejects. (*Ibid.*) The WCAB in *Cervantes* underscores that section 4062(b) "unequivocally provides that it is the *defendant* that may initiate that statute's spinal surgery second opinion procedure," which is confirmed by the unambiguous language of section 4062(a) providing that *employer objections* to recommendations for spinal surgery are subject to subdivision (b). (*Cervantes*, *supra*, 74 Cal.Comp.Cases at p. 1345.) The employer's objection may be made only after the treating physician's request has been denied by utilization review. The board explained: "It may seem redundant to provide for a defendant to object again after its own [utilization review] has just denied the spinal surgery request, but in the context of spinal surgery this is exactly what sections 4062(b) and 4062(a) specify. The legislative framework for spinal surgery cases is simply different than it is for non-spinal surgery cases because, at every step, section 4062(b) places the onus on the defendant." (*Cervantes*, *supra*, 74 Cal.Comp.Cases at p. 1345.) The statute recognizes only employer objections to a treating physician's spinal surgery recommendation, and in line with this allocation of responsibility to the employer to pursue the spinal surgery second opinion process, also requires the employer to file a declaration of readiness to proceed with a hearing before the WCAB if the second opinion report does not recommend surgery. (§ 4062(b).) Finally, *Cervantes* clarifies that the employer must both complete its own utilization review and make its section 4062(b) objection within 10 days of receiving the treating physician's report recommending spinal surgery. (*Cervantes*, *supra*, 74 Cal.Comp.Cases at pp. 1351-

Cal Lab Code § 3600

(a) (10) Except for psychiatric injuries governed by subdivision (e) of Section 3208.3, where the claim for compensation is filed after notice of termination or layoff, including voluntary layoff, and the claim is for an injury occurring prior to the time of notice of termination or layoff, no compensation shall be paid unless the employee demonstrates by a preponderance of the evidence that one or more of the following conditions apply:

(A) The employer has notice of the injury, as provided under Chapter 2 (commencing with Section 5400), prior to the notice of termination or layoff.

(B) The employee's medical records, existing prior to the notice of termination or layoff, contain evidence of the injury.

(C) The date of injury, as specified in Section 5411, is subsequent to the date of the notice of termination or layoff, but prior to the effective date of the termination or layoff.

(D) The date of injury, as specified in Section 5412, is subsequent to the date of the notice of termination or layoff.

For purposes of this paragraph, an employee provided notice pursuant to Sections 44948.5, 44949, 44951, 44955, 72411, 87740, and 87743 of the Education Code shall be considered to have been provided a notice of termination or layoff only upon a district's final decision not to reemploy that person.

A notice of termination or layoff that is not followed within 60 days by that termination or layoff shall not be subject to the

provisions of this paragraph, and this paragraph shall not apply until receipt of a later notice of termination or layoff. The issuance of frequent notices of termination or layoff to an employee shall be considered a bad faith personnel action and shall make this paragraph inapplicable to the employee.

Lighting up or aggravation of a preexisting condition by an industrial injury

New or aggravated injury which results from medical or surgical treatment of industrial injury is compensable, whether doctor was furnished by employer, his insurance carrier, or was selected by employee. *Fitzpatrick v. Fidelity & Casualty Co.* (1936) 7 Cal 2d 230, 60 P.2d 276, 1936 Cal LEXIS 622.

Compensation is recoverable for disability which results from the aggravation of a pre-existing disease if the aggravation is reasonably attributable to an industrial accident; but compensation is not recoverable for disability which results, irrespective of such accident, from the normal progress or development of a pre-existing disease. *Industrial Indem. Co. v. Industrial Acci. Com.* (1949, Cal App) 95 Cal App 2d 443, 213 P.2d 11, 1949 Cal App LEXIS 1132; *De La Tova v. Industrial Acci. Com.* (1955, Cal App 2d Dist) 137 Cal App 2d 516, 290 P.2d 377, 1955 Cal App LEXIS 1218.

LESTER FERGUSON, Petitioner, v. INDUSTRIAL ACCIDENT COMMISSION et al., Respondents, 23 Cal. Comp. Cas 108; 1958 Cal. Wrk. Comp. LEXIS 194; 50 Cal. 2d 469; 326 P.2d 145, June 6, 1958

1) The rule requiring apportionment is stated in *Ferguson v. Industrial Acc. Com.*, 50 Cal.2d 469, at pages 477, 478 [326 P.2d 145], as follows: "The rule is, of course, that where a disability is due entirely to an industrial injury and the lighting up or aggravation of a preexisting condition by such industrial injury, the employer is required to compensate for the entire disability so caused (within the limits defined in Lab. Code, § 4663) and there is no apportionment of disability as between the industrial accident on the one hand and that due to the industrially caused aggravation of the employe's preexisting physical condition. 2) But if the entire disability is partly due to industrial disability growing out of the immediate injury (including such industrially caused aggravation or lighting up of a preexisting dormant condition) and, in part, to a nonindustrial disability resulting from normal symptoms, effects or progress of a preexisting disease or condition, then there is an apportionment of the percentage of the disability due to

the industrial cause (the injury) and the percentage due to the disease itself and its symptoms, effects and progress apart from the injury." (*Tanenbaum v. Industrial Acc. Com.*, 4 Cal.2d 615 [52 P.2d 215]; *City of Glendale v. Industrial Acc. Com.*, 153 Cal.App.2d 213 [314 P.2d 182]; *De La Tova v. Industrial Acc. Com.*, 137 Cal.App.2d 516 [290 P.2d 377]; *Bowler v. Industrial Acc. Com.*, 135 Cal.App.2d 534 [287 P.2d 562].) 3) Whether disability is due entirely to the injury, including the aggravating effect of the injury upon a preexisting condition, or partly due to a continuance or normal progress of the preexisting condition is a question of fact for the commission to determine (*De La Tova v. Industrial Acc. Com.*, supra, at p. 522), but the question "generally can only be determined by medical testimony." (*Bowler v. Industrial Acc. Com.*, supra, at p. 542.)

Granado v. Workmen's Comp. App. Bd. (1968) 69 Cal. 2d 399, 404 [71 Cal. Rptr. 678, 445 P.2d 294]; states as follows:

"There can be no doubt that medical expense is not apportionable. Neither section 4600 nor any of the succeeding sections in the article of the code dealing with medical and hospital treatment state or even suggest that the employer may pay part of the expense. So long as the treatment is reasonably required to cure or relieve from the effects of the industrial injury, the employer is required to provide the treatment, and treatment for nonindustrial conditions may be required of the employer where it becomes essential in curing or relieving from the effects of the industrial injury itself. Medical treatment unrelated to the industrial injury need not be furnished by the employer. If medical expenses reasonably necessary to relieve from the industrial injury were apportionable, a workingman, who is disabled, may not be able to pay his share of the expenses and thus forego treatment. Moreover, the uncertainties attendant to the determination of

the proper apportionment might cause employers to refuse to pay their share until there has been a hearing and a decision on the question of apportionment, and such delay in payment may compel the injured workingman to forego the prompt treatment to which he is entitled."

END

CIGA must pay “covered claims.”

(§ 1063.2, subd. (a).) A covered claim is an obligation of an insolvent insurer. (§ 1063.1, subd. (b).) However, “[c]overed claims” does not include . . . any claim to the extent it is covered by any other insurance.” (§ 1063.1, subd. (c)(9).) In 2005, section 1063.1, subdivision (c)(13) was added by Assembly Bill No. 817 to provide that covered claims “include obligations arising under an insurance policy written to indemnify a permissibly self-insured employer . . . for its liability to pay workers’ compensation benefits in excess of a specific or aggregate retention.”¹ Subdivision (c)(13) does not cross-reference subdivision (c)(9) or purport to eliminate statutory exceptions to CIGA’s liability.

Filed 3/3/10

CERTIFIED FOR PUBLICATION

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION TWO

CITY OF LAGUNA BEACH,

Plaintiff and Appellant,

v.

CALIFORNIA INSURANCE GUAR. ASSOCIATION,

Defendant and Respondent.

APPEAL from a judgment of the Superior Court of Los Angeles County. Malcolm H. Mackey, Judge. Affirmed.

Roberson, Kimball & Jaltorossian, Stephen D. Roberson and Blake S. Posner for Plaintiff

and Appellant.

Locke Lord Bissell & Liddell, C. Guerry Collins and Conrad V. Sison for Defendant and Respondent.

In this opinion we resolve the following issue: Did the addition of subdivision (c)(13) to Insurance Code section 1063.1¹ abrogate *Denny’s Inc. v. Workers’ Comp. Appeals Bd.* (2003) 104 Cal.App.4th 1433 (*Denny’s*)? The answer is no. We therefore conclude that the trial court properly invoked the *Denny’s* rule when it granted summary judgment and concluded that the appellant City of Laguna Beach (City) cannot obtain reimbursement from respondent California Insurance Guarantee Association (CIGA) under section 1063.1, subdivision (c)(13). Though that provision renders the obligation of an insolvent excess workers’ compensation insurer a “covered claim” that CIGA must ordinarily reimburse, CIGA need not reimburse a permissibly self-insured employer for benefits paid to an employee for cumulative injury if the employer’s liability is based in part on a period of time when the employer was self-insured and chose not to buy excess insurance for the particular risk.

The judgment is affirmed.

FACTS

Background

Continental Casualty Company (Continental) issued a workers’ compensation policy to the City providing coverage from May 1, 1998, to May 1, 1999. The policy was excess to the City’s \$275,000 self-insured retention and covered cumulative injury only if it first manifested during the policy period. Reliance National Indemnity Company (Reliance) issued a workers’ compensation policy to the City for the period May 1, 1999, to July 18, 2001. This policy, too, was excess to the City’s \$275,000 self-insured retention. But it differed from Continental’s policy in that it was triggered by cumulative injury if the last date of

exposure to the conditions causing the disease occurred during the policy period.

A City employee filed a workers’ compensation claim for cumulative injury from 1986 to June 18, 1999. The case was resolved in 2001, but the employee reopened the case in 2003 to seek more benefits. The City incurred workers’ compensation liability that exceeded its self-insured retention and sought reimbursement from Continental. In addition, because Reliance was insolvent, the City sought reimbursement from CIGA. Continental and CIGA both determined that they did not have to pay the City’s claim.

The City’s action

The City sued CIGA and Continental and requested a declaration that they owe the City reimbursement. CIGA filed a motion for summary judgment or summary adjudication. It argued that the City’s self-insured status and the Continental policy constituted other insurance under section 1063.1, subdivision (c)(9) and therefore CIGA had no statutory obligation to pay any portion of the benefits that were due under Reliance’s policy.

According to the trial court, the City bore the burden of proving the nonexistence of other insurance but failed to meet its burden. The trial court granted CIGA’s motion and entered judgment.

This timely appeal followed.

DISCUSSION

We review summary judgment de novo. (*Reyes v. Kosha* (1998) 65 Cal.App.4th 451, 466, fn. 6.) In assessing whether the trial court properly granted summary judgment, the pivotal question presented is whether the City’s claim is a covered claim under section 1063.1, subdivision (c)(13) or barred under subdivision (c)(9) because its self-insured status qualifies as other insurance. The City contends that section 1063.1, subdivision (c)(13) clearly applies to this case, and that the trial court’s reliance on *Denny’s* is unexplainable. In particular, the City posits that section 1063.1, subdivision (c)(13) specifically abrogated *Denny’s*. What the City fails to appreciate is that the reach

of section 1063.1, subdivision (c)(13) is unclear, and we are obligated to harmonize it with *Denny’s* to the extent possible. Finally, the City contends that CIGA failed to meet its burden of proof. We disagree.

A. The applicable interpretive principles.

Before assessing the impact of section 1063.1, subdivision (c)(13) on *Denny’s*, it behooves us to acknowledge that “[u]nless expressly provided, statutes should not be interpreted to alter the common law, and should be construed to avoid conflict with common law rules. [Citation.]” (*Goodman v. Zimmerman* (1994) 25 Cal.App.4th 1667, 1676.) As a result, “[a] statute will be construed in light of common law decisions, unless its language “clearly and unequivocally discloses an intention to depart from, alter, or abrogate the common-law rule concerning the particular subject matter” [Citations.] [Citation.]” [Citation.] Accordingly, “[t]here is a presumption that a statute does not, by implication, repeal the common law. [Citation.] Repeal by implication is recognized only where there is no rational basis for harmonizing two potentially conflicting laws.” [Citation.]” (*California Assn. of Health Facilities v. Department of Health Services* (1997) 16 Cal.4th 284, 297.)

Moreover, when interpreting a statute, we must “ascertain the intent of the Legislature so as to effectuate the purpose of the law.” (*Dyna-Med, Inc. v. Fair Employment & Housing Com.* (1987) 43 Cal.3d 1379, 1386.) “Where uncertainty exists consideration should be given to the consequences that will flow from a particular interpretation. [Citation.] Both the legislative history of the statute and the wider historical circumstances of its enactment may be considered in ascertaining the legislative intent. [Citations.]” (*Id.* at p. 1387.) If the statute does not have a plain meaning and legislative history is unhelpful, we must “apply reason, practicality, and common sense to the language at hand.” [Citation.]” (*U.D. Registry, Inc. v. Municipal Court* (1996) 50 Cal.App.4th 671, 674.)

B. The common Law.

When an employee suffers a cumulative injury, he “may claim workers’ compensation benefits against any one or more of successive employers or insurance carriers that employed or insured the employee during a maximum one-year injury period. [Citations.]” (*Denny’s, supra*, 104 Cal.App.4th at p. 1437; Lab. Code, § 5500.5, subd. (a) [setting the one-year period during which employers and insurers are liable].) The employers and insurers are jointly and severally liable for the entire award. They can “apportion their relative liabilities in separate [Workers’ Compensation Appeals Board] proceedings. [Citations.]” (*Id.* at pp. 1437–1438.) “[W]here an insured has overlapping insurance policies and one insurer becomes insolvent, the other insurer, even if only a secondary or excess insurer, is responsible for paying the claim. In other words, CIGA is an insurer of last resort and does not assume responsibility for claims where there is any other insurance available. [Citation.]” (*Id.* at p. 1439.)

In *Denny’s*, an employee claimed that she suffered a cumulative injury and the year-long cumulative injury period spanned May 22, 1996, to May 22, 1997. (*Denny’s, supra*, 104 Cal.App.4th at p. 1436.) The employer was self-insured through July 31, 1996. (*Ibid.*) Thereafter, it was covered by a primary workers’ compensation policy from a private insurer. When the insurer was declared insolvent, the employer sought reimbursement from CIGA. The court concluded that the self-insured retention was other insurance. The court noted that “[o]ur determination comports with the intent of the Guarantee Act. As an insurer of last resort, CIGA assumes responsibility for claims *only* when no secondary insurer is available. [Citations.] The Legislature did not establish . . . CIGA to protect *Denny’s* as

a self-insurer, but rather, to protect [the injured employee] as a member of the insured public by ensuring she received a full disability award. [Citations.]” (*Id.* at pp. 1441–1442.)

The *Denny’s* court went on to explain: “We also find no reason to assess liability against CIGA on equity grounds. As a self-insurer, *Denny’s* placed itself in the position of a private insurer. If *Denny’s* had been covered by a third party insurer instead of being self-insured during the first portion of [the employee’s] cumulative injury period, that insurer would be liable for the entire disability award. [Citation.] *Denny’s* made a risk-management decision to self-insure, gambling that it could lower its costs by not purchasing third party workers’ compensation insurance. *Denny’s* cannot reap the benefits of self-insurance without accepting its burdens. Moreover, *Denny’s* could have limited its liability by purchasing ‘a special excess workers’ compensation policy to discharge any or all of [its] continuing obligations as a self-insurer to pay compensation or to secure the payment of compensation.’ [Citation.] By not purchasing a special excess workers’ compensation policy, *Denny’s* effectively chose not to insulate itself from the long tail of potential self-insurance liability.” (*Denny’s, supra*, 104 Cal.App.4th at p. 1442.)

C. The statutory scheme.

CIGA must pay “covered claims.” (§ 1063.2, subd. (a).) A covered claim is an obligation of an insolvent insurer. (§ 1063.1, subd. (b).) However, “[c]overed claims’ does not include . . . any claim to the extent it is covered by any other insurance.” (§ 1063.1, subd. (c)(9).) In 2005, section 1063.1, subdivision (c)(13) was added by Assembly Bill No. 817 to provide that covered claims “include obligations arising under an insurance policy written to indemnify a permissibly self-insured employer . . . for its liability to pay workers’ compensation benefits in excess of a specific or aggregate retention.”¹ Subdivision (c)(13) does not cross-reference subdivision (c)(9) or purport to eliminate statutory exceptions to

CIGA’s liability.

D. Interpretation of section 1063.1, subdivision (c)(13).

Section 1063.1, subdivision (c)(13) does not express an intent to abrogate *Denny’s*. If *Denny’s* was abrogated, it is only by implication. We do not perceive a direct conflict between the statute and common law. *Denny’s* did not hold that CIGA was relieved of its duty to fulfill the obligation of an insolvent excess workers’ compensation insurer when an employer was self-insured up to a specific amount. *Denny’s* involved a primary insurer.

The question is whether there is an indirect conflict, i.e., whether the policy and reasoning in *Denny’s* interfere with section 1063.1, subdivision (c)(13) in a context involving an excess insurer. In broad terms, what *Denny’s* held is that CIGA does not have to provide a safety net for an employer to the extent it gambled on self-insuring without private insurance for any portion of the cumulative injury period. Thus, section 1063.1, subdivision (c)(13) and *Denny’s* can be harmonized when an employer has excess insurance for the entire year of liability, the excess insurer becomes insolvent and a claim is then made to CIGA. In that situation, coverage afforded by CIGA would not rescue the employer from a gamble and therefore would not transgress the policy and reasoning set forth in *Denny’s*.

But what happens in a scenario like the present case where the employer took a gamble for part of the period of cumulative injury? The policy and reasoning of *Denny’s* would cut off CIGA’s liability. Can section 1063.1, subdivision (c)(13) and *Denny’s* still be harmonized? Yes.

To illustrate, we find it useful to employ a hypothetical. If an employer is alone in insuring six months of an employee’s cumulative injury period, the employer has excess coverage over \$200,000 for the rest of the period, and the employee obtains an award of \$700,000, there are three insurance obligations. There is the employer’s obligation to pay the first \$200,000 (obligation A), the employer’s joint and several obligation to pay \$500,000

(obligation B), and the insurer’s joint and several obligation to pay \$500,000 (obligation X).

Obligation A stands alone, but obligation B and obligation X overlap. If the excess insurer becomes insolvent, CIGA can argue based on *Denny’s* that obligation X is not a covered claim. Why? While the language of section 1063.1, subdivision (c)(13) would otherwise make obligation X a covered claim, obligation B represents overlapping other insurance for the exact same liability. As well, obligation B is not the obligation of an insolvent insurer, so obligation B could never qualify as a covered claim under section 1063.1, subdivision (b). Section 1063.1, subdivision (c)(9) is triggered and takes obligation X out of the realm of covered claims because CIGA is only supposed to be an insurer of last resort. *Denny’s* does not conflict with section 1063.1, subdivision (c)(13). Rather, *Denny’s* merely enforces the exception to covered claims in section 1063.1, subdivision (c)(9).

The City bases its contrary interpretation on the legislative history. But the legislative history is not the panacea the City hopes for.

The final senate floor analysis for Assembly Bill No. 817 creates confusion rather than clarity. It stated: “According to the author’s office, the purpose of the bill is to clearly require CIGA to pay claims resulting from insolvent insurers who sold special excess policies to public and private self-insured employers. . . . [¶] An Appeals Court decision in the matter of [*Denny’s*] ruled that workers’ compensation self insured employers were some type of ‘other insurance’ and therefore CIGA did not guarantee the insolvent carrier that issued a specific excess policy. The decision has created additional litigation between CIGA and the entire self insured community to overturn the decision. According to the author, [Assembly Bill No. 817] is a legislative compromise that puts into statute the agreement to the key issues worked out by the affected parties themselves. [¶] This bill was substantially amended in the Senate because the parties had not agreed to language prior to the bill’s passage in the Assembly.

The amendments were worked out in cooperation with representatives of employers (both private and public), CIGA, the Self-Insurers' Security Fund, and Bipartisan committee staff of both the Assembly and Senate." (Assem. Floor Analysis, Conc. Sen. Amends. to Assem. Bill No. 817 (2005-2006 Reg. Sess.), Sept. 8, 2005.)

This analysis suggests that the Legislature did not appreciate that, as the City concedes, *Denny's* involved a primary insurer rather than an excess insurer. And while the analysis refers to litigation to overturn *Denny's*, it also refers to a compromise by various parties. What was the compromise? Moreover, the analysis does not suggest that the bill was designed to remove permissibly self-insured employers from the definition of other insurance.

A senate committee analysis stated that the purpose of the bill was "to reverse a court ruling involving *Denny's* restaurants in which CIGA was relieved of the obligation to pay workers' compensation claims arising under a policy of specific and aggregate excess coverage due to the presence of 'other insurance.'" (Sen. Com. on Banking, Finance & Insurance, Analysis of Assem. Bill No. 817 (2005-2006 Reg. Sess.), June 28, 2005.) This analysis, however, predates the final senate floor analysis, and once again fails to appreciate that *Denny's* did not involve excess insurance. More importantly, the language of section 1063.1, subdivision (c)(13) does not purport to repeal *Denny's* and, as we have shown, it can be harmonized with *Denny's*.

Because the legislative history does not help us interpret section 1063.1, subdivision (c)(13), we are left with the rules we have already applied: the statute must be harmonized with common law, and we must apply practicality and common sense. We have done so. As a matter of policy, we find no reason to saddle CIGA with a liability that exonerates an employer's decision to lower its costs and gamble on not being insured for a portion of the cumulative injury period.

E. Application of *Denny's* to the City's claim.

The undisputed facts in CIGA's separate statement established that it was entitled to summary judgment. We therefore reject the City's contention that CIGA did not meet its burden of proof.¹

The City's employee stopped working on June 18, 1999, and filed a claim for cumulative injuries. The City admits it was solely responsible for the first \$275,000, and the entities that provided excess insurance from June 18, 1998, to June 18, 1999, were jointly and severally liable for an excess award. Because it did not have excess insurance, the City was the de facto insurer for awards that went over \$275,000 and were based on liability that attached from June 18, 1998, to May 1, 1999. Reliance provided excess insurance over \$275,000 for liability that attached from May 1, 1999, to June 18, 1999. We assume for purposes of this appeal only that the Continental policy was not triggered.¹ Thus, the employee was entitled to a joint and several award against the City and Reliance for the award to the extent it exceeded \$275,000. The picture is this: From June 18, 1998, to May 1, 1999, the City chose not to purchase excess insurance that would cover cumulative injuries. In other words, the City took a gamble that it would not be liable for more than \$275,000 for a cumulative injury. Under the policy enunciated in *Denny's*, CIGA need not pay.

The parties devote much of their briefs discussing whether CIGA met its burden of proof with respect to whether the Continental policy was other insurance. But if Continental covered the cumulative injury, CIGA is not liable because Continental's policy is other insurance. And if Continental did not cover the cumulative injury, CIGA is not liable because the City's self-insured status is other insurance for the portion of the cumulative injury period before Reliance was on the risk. Thus, whether Continental provided coverage is moot.

DISPOSITION

The judgment is affirmed. CIGA shall recover its costs on appeal.

CERTIFIED FOR PUBLICATION.

_____, J.

ASHMANN-GERST

We concur:

_____, Acting P. J.

DOI TODD

_____, J.

CHAVEZ

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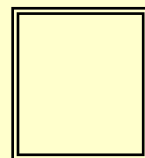
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