2024 EMPLOYMENT LAW Conference

Off to work we go!

Best Practices for Effective Management of an Initial Work Comp Claim

Fisher Phillips

FLOYD SKEREN MANUKIAN LANGEVIN

Welcome

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Presenters:

Daniel Brown

Floyd Skeren Manukian Langevin

Partner

(818) 651-7039
Daniel.brown@floydskerenlaw.com

Terry Smith

Floyd Skeren Manukian Langevin

Partner

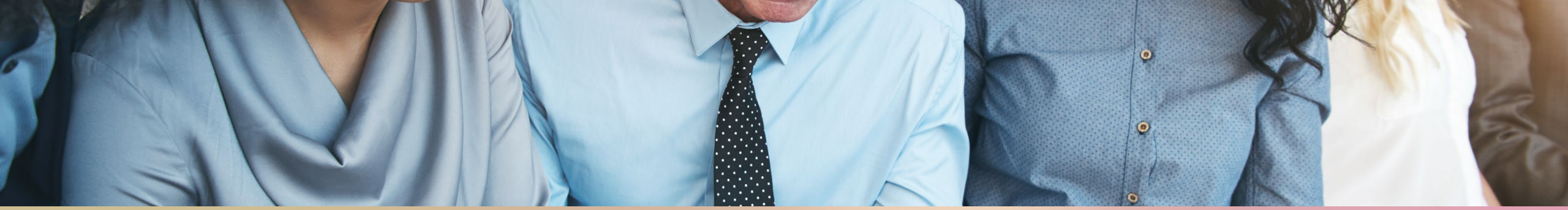
(818) 639-7630
terry.smith@floydskerenlaw.com

Kyle Uebelhardt

Floyd Skeren Manukian Langevin

Partner

(818) 639-7633
kyle.uebelhardt@floydskerenlaw.com



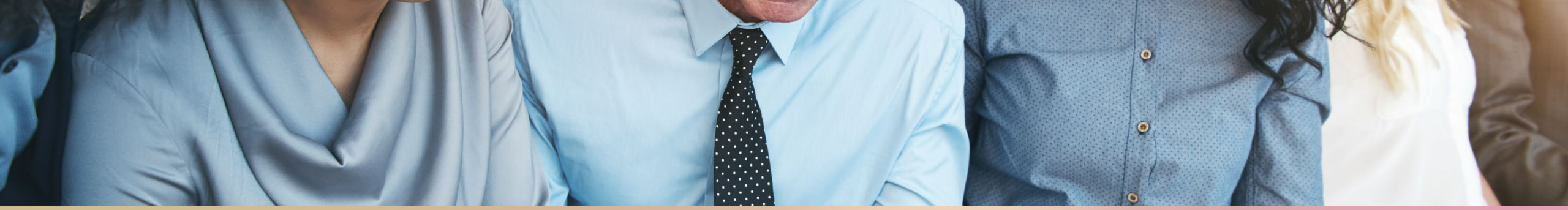
Introduction

We will review:

- What constitutes notice of a claim, what are your legal requirements triggered by notice, and what are your business/legal considerations.
- Importance of Investigation and initial documentation
- Importance of analyzing work restrictions and modified duty
- How to properly document termination vs. resignation
- CCR 10109 and the legal requirements of good faith investigation.
- How to use Medical Control, MPN, and UR to your advantage
- Choice of Doctor/Compensability Exams
- What to expect when a claim becomes litigated before the WCAB.
- Development of the Record-
  - MPN Consults versus PQME's - Pros and Cons

Return to Work

- Considerations when requiring resignation as part of settlement



Notice of a Claim

Notice of a Claim

- Workplace injuries and/or illnesses must be reported to the employer in a timely manner. Under Labor Code § 5400, the general rule is that employees have a duty to report their work-related injury or illness within 30 days from the date of the incident.
- While the employee is required to report their work related injury, sometimes the manner in which a potential injury is reported is not so clear.

  - Example 1- "I was lifting a jackhammer, felt my back go out, and fell to the floor. I need to see a doctor."

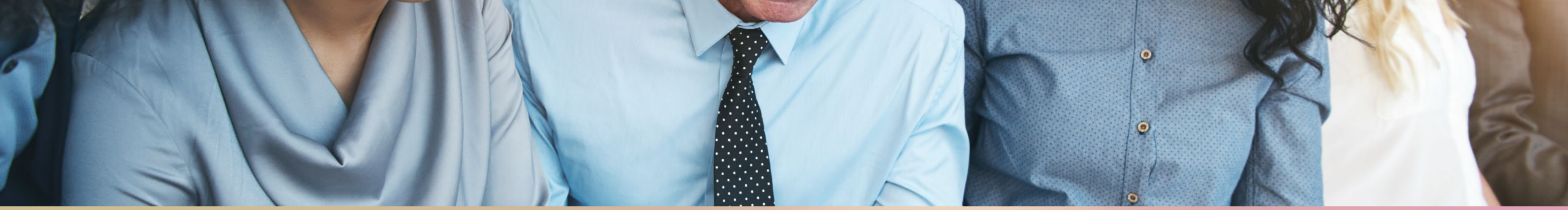
  - Example 2- "I woke up this morning with my back feeling a lot of pain. The amount of work we did yesterday was out of the norm."

  - Example 3- "My back is in a lot of pain today and I think I need to lay down for a bit."

Notice of a Claim

- There are situations where an employer will be deemed to be put on notice of a workplace injury despite the employee's failure to directly report. In such circumstances, the employer's legal obligations may become triggered even though the employee did not report the injury.

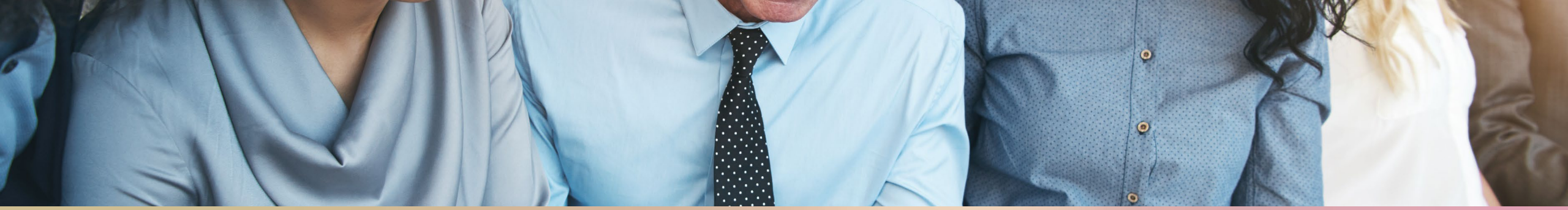
- *LISTING V. W.C.A.B.*
  (1998) 63 CAL.COMP.CASES 459
  - Tacit understanding of possible industrial injury is not sufficient.
  - Reporting of injury triggering employer/carrier obligations under Reynolds must be supported by substantial evidence.
  - *Still evaluated on the factual circumstances*.
  - Does the employee's complaints or symptoms, under the circumstances, suggest a potential connection to the job activities?



Employer Obligations Upon Receiving Notice of Workplace Injury

Employer Obligations Upon Receiving Notice of Workplace Injury

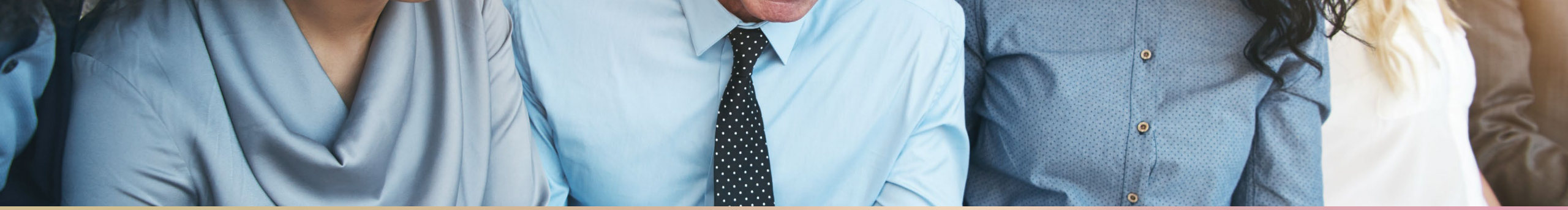
- Provide a workers' compensation claim form within one working day
- Return a copy of the completed form to the employee within one working day of receipt
- If your employees are covered by a Medical Provider Network (MPN), make sure the injured worker is provided with a complete MPN employee notification and that an initial medical evaluation is arranged with an MPN physician
- Forward the claim form, along with your report of occupational injury or illness, to the claims administrator within one working day of receipt
- Within one working day of receiving the employee's claim, authorize up to $10,000 in appropriate medical treatment
- Provide transitional work (light duty) whenever appropriate
- If the employee is the victim of a crime that happened at work, you must give notice of workers' compensation eligibility within one working day of the crime



Best Practices After Notice Along With Business and Legal Considerations

Best Practices After Notice Along With Business and Legal Considerations

- Understand that the issue of whether the employer was put on notice is evaluated on a case by case basis.
- Document the incident, including whether the employee reported another cause for the injury, and/or refused acceptance of a Claim Form.
- Best practice may be to provide a Claim Form if notice is questionable, while "balancing" based upon the type of employment.
  - Reynolds v. WCAB- Failure to provide a claim form may toll the statute of limitations.
- Quick reporting to claims department.



Importance of Early Investigation and Documentation (Legal Considerations)

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- Labor Code Section 5402
  - (a) Knowledge of an injury, obtained from any source, on the part of an employer, the employer's managing agent, superintendent, foreman, or other person in authority, or knowledge of the assertion of a claim of injury sufficient to afford opportunity to the employer to make an investigation into the facts, is equivalent to service under Section 5400.
  - (b)(1) If liability is not rejected within 90 days after the date the claim form is filed under Section 5401, the injury shall be presumed compensable under this division. The presumption of this subdivision is rebuttable only by evidence discovered subsequent to the 90-day period.
    - NOTE: LC 5402 does not apply to admitted injuries. You may change acceptance into a later denial upon sufficient grounds.

Importance of Early Investigation and Documentation (Legal Considerations)

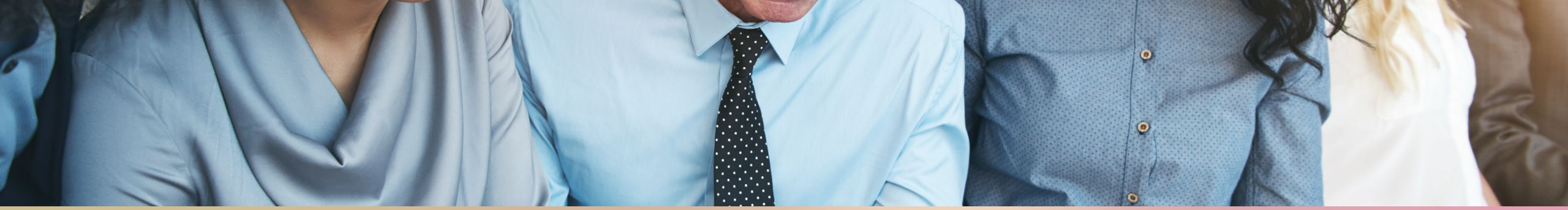
- CCR §10109. Duty to Conduct Investigation; Duty of Good Faith.
- (a) To comply with the time requirements of the Labor Code and the Administrative Director's regulations, a claims administrator must conduct a reasonable and timely investigation upon receiving notice or knowledge of an injury or claim for a workers' compensation benefit.
- (b) A reasonable investigation must attempt to obtain the information needed to determine and timely provide each benefit, if any, which may be due the employee.
- *(1) The administrator may not restrict its investigation to preparing objections or defenses to a claim, but must fully and fairly gather the pertinent information, whether that information requires or excuses benefit payment. The investigation must supply the information needed to provide timely benefits and to document for audit the administrator's basis for its claims decisions. The claimant's burden of proof before the Appeal Board does not excuse the administrator's duty to investigate the claim.*
- (2) The claims administrator may not restrict its investigation to the specific benefit claimed if the nature of the claim suggests that other benefits might also be due.

Importance of Early Investigation and Documentation (Strategic Considerations)

- Evidence becomes more difficult to obtain with the passage of time.
  - Witness memories fade.
  - Records may be destroyed.
  - Contemporaneous documentation carries more weight.
  - It becomes more difficult to document “after the fact”.
- Some of our client’s take the position that it is entirely Applicant’s burden of proof to establish injury.
  - “let’s sit back and do nothing”
  - Is that appropriate under CCR 10109?
- Recognize if the dispute to AOE/COE is derived from a factual dispute, medical dispute, or both.

Importance of Early Investigation and Documentation (Strategic Considerations)

- Every workers' compensation claim involves overlapping issues with employment law.
  - ❖Disability Discrimination
  - ❖Wage and Hour
  - ❖Hostile work environment, sexual harassment
- Early identification of overlapping issues is extremely important
- Make sure the "left hand knows what the right hand is doing".
- Communicate and share in discovery
- Understand that legal advice and determinations in workers' compensation can and will impact employment law liability!



Work Restrictions and Modified Duty

Work Restrictions and Modified Duty

- Understand that your obligations for offering and evaluating the ability to bring an injured employee back to work are separate and distinct from your obligations under employment law!
- Workers' Compensation
  - Per California Code of Regulations§ 10116.9(h), modified work or "light duty" means regular work modified so that the employee has the ability to perform all the functions of the job and that offers wages and compensation that are at least 85 percent of those paid to the employee at the time of injury, and located within a reasonable commuting distance of the employee's residence at the time of injury.
  - Meet the work restrictions in the doctor's report (Is an alternative job ok?)
  - Last at least 12 months (Independent of good-faith personnel action)
  - Be within a reasonable commuting distance of where you lived at the time of injury.

Work Restrictions and Modified Duty

- Workers' Compensation offer of modified duty can be an incredible tool to cut off temporary disability exposure.
  - An employees failure to accept the offer within 30 days gives the opportunity to cut off temporary disability and preclude an offer of supplemental displacement voucher.
- Whether an employee has resigned, been terminated, or laid off, best practice is to still make the written offer. Document your ability to offer modified duty, the understanding of why the employment relationship ended, and your ability to offer modified duty "but for" the end of the employment relationship.

Work Restrictions and Modified Duty

- In the case of *Anzelde v. WCAB (1996)* 61 Cal. Comp. Cases 1458 (writ denied), the California WCAB made it clear that a termination for cause justified the termination of the injured worker's right to vocational rehab. That same ruling was extended to the justification for terminating that employee's TTD.
- So why is it important to still make the offer?
  - A dispute may still exist as to whether the termination was done in good-faith.
  - In circumstances of resignation, a dispute may exist as to whether the resignation was "pre-planned" or whether the resignation occurred due to the inability to perform the job due to pain/complaints/disability related to the industrial injury.
- Following these procedures gives you the best opportunity to defend entitlement to temporary disability. Furthermore, this practice gives you the best opportunity to resolve a temporary disability dispute without litigation surrounding the reason for termination, resignation, lay-off.

Work Restrictions and Modified Duty

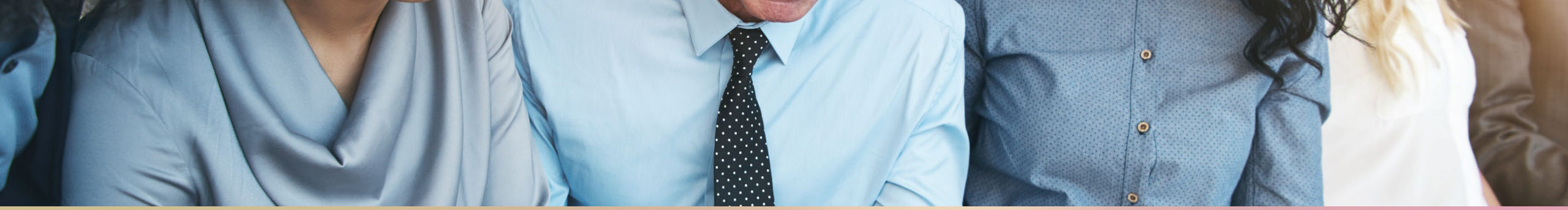
- Temporary Disability benefits may often be the most expensive indemnity benefit. For this reason, this issue is often contested.
  - Have proof that the applicant was terminated.
  - Be able to show that the termination was “for cause.” Typically the employee handbook should lay out what constitutes violation of company policies.
    - Documentation prior to injury is best, and be wary of documentation obtained after injury!
  - Be able to show that the termination was “in good faith.” This will help employers avoid 132a and discrimination claims.
  - Have proof that modified duty was or would have been available. Evidence of this could include all of the letters the adjuster sent to the injured worker regarding offers of return to work including witness testimony from the insured.
  - Make sure modified duty was within the injured worker’s restrictions. Here, you would look to medical evidence within the PTP’s recommendations.
    - Be careful of offering modified duty that may “degrade” the perception of prior employment.

Work Restrictions and Modified Duty

- The employment law equivalent to an offer of modified duty is referred to as “reasonable accommodation”. That term is not used in the evaluation process for workers’ compensation.
- Through employment law, the offer of a reasonable accommodation REQUIRES an interactive process to determine whether the injured/disabled worker can perform the “essential functions of the job” when given a reasonable accommodation.
- There is no interactive process required in workers’ compensation, nor an evaluation of whether you can perform essential functions of the job. However, we must always be wary of whether the offer of modified duty/reasonable accommodation is punitive in nature.

Work Restrictions and Modified Duty

- Going back to communication between employment law and workers' compensation counsel…
  - Is the employer being advised of the separate and distinct obligation for evaluating an offer of modified duty and/or reasonable accommodation?
  - Offering modified work/reasonable accommodation on the one side, does not obviate liability for the other.
  - Reasonable accommodation and interactive process can be used as a tool to diminish liability and/or defend the nature and extent of injury.
    - Doctor says worker is totally temporary disabled (can't do anything), but through the interactive process, Applicant conveys he is able to do certain functions of the job.
    - Consider cross-examination, request for supplemental, and/or interrogatories to challenge the doctor's opinion on work restrictions.



Documentation of Termination, Resignation, or Layoff

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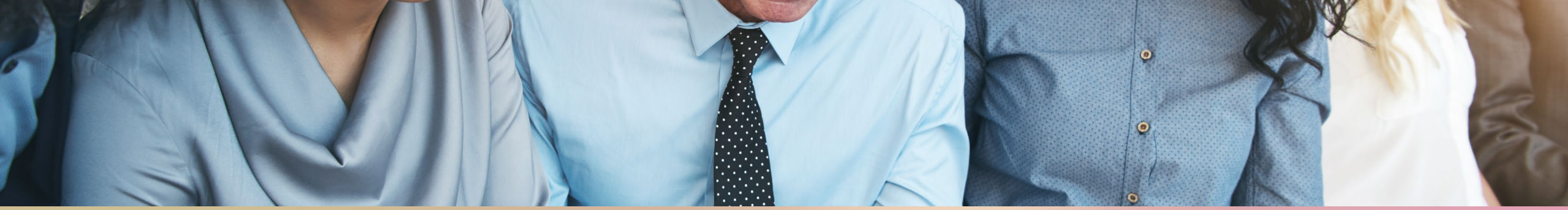
- LC 3200(a)(10) codifies the post-termination defense and allows for a complete bar to workers' compensation benefits when a claim is filed after termination.
  - Notably, the defense does not apply to a worker quitting or resigning from employment.
  - Legislative intent behind the post-termination defense was to preclude claims being filed after termination as a means to retaliate against the employer.
  - Thus, if an employee decides to resign or quit, it is presumed the decision was made on their own volition, and therefore not presumed in retaliation.

Documentation of Termination, Resignation, or Layoff

- All to often, the employer fails to document the end of the employment relationship, including the rationale for the end of the relationship. This can lead to significant disputes as to whether the Applicant was terminated, voluntarily resigned, or ended the employment relationship due to his alleged injury.
- Examples:
  - Applicant was a “no call, no show” as the trigger for the end of the relationship.
  - Does this mean the worker resigned? Does this mean the worker resigned as a result of injury/disability?
  - Does a termination automatically impute based upon an employees “no call, no show”?

Documentation of Termination, Resignation, or Layoff

- In circumstances such as this, proper documentation is key.
  - While the worker may have been a “no call, no show”, that does not necessarily mean they are resigning from employment.
  - Consider issuing a formal termination letter to implicate the post-termination defense, making sure to note the employer policy and procedures with respect to no call, no shows, to show the termination was done in good faith.
  - Consider reaching out to the employee to determine the basis for the “no call, no show”. There could very well be a reasonable explanation on the employees behalf, in which you might consider keeping the employee employed, or at a minimum, be able to show that your follow ups and termination was derived in good faith versus discriminatory action.
  - Document the employees reason for the “no call, no show”. The explanation provided can be evidence as to whether resignation was done on the employees own volition, as opposed to disability.
  - Even if the employee does not respond, documentation regarding the number of contact attempts and the decision to terminate, can be used as evidence of good faith.



Medical Control, MPN, UR

Medical Control, MPN, UR

- Medical control, medical provider network, and utilization review are substantial tools to control medical treatment cost, limit liberal treatment opinions, overall costs of the claim, and indemnity benefits that may be owed.
- These tools can only be utilized in claims that are admitted AOE/COE. In cases of denials, workers have free choice of physician, most likely more liberal and connected with Applicant's attorney's, and without utilization review to control medical treatment.
- When a claim is denied, medical treatment providers will record a lien, typically for an amount far more excessive than pre-negotiated rates between the insurance carrier and MPN.
- Medical treatment liens must then be resolved and or litigated, often with disputes as to the reasonableness and necessity of treatment, but also whether the fees for such treatment are reasonable.
- Liens most often exceed the indemnity value of the claim, and is often averaged as 55% of the overall indemnity value, inclusive of temporary disability and permanent disability.

Medical Control, MPN, UR

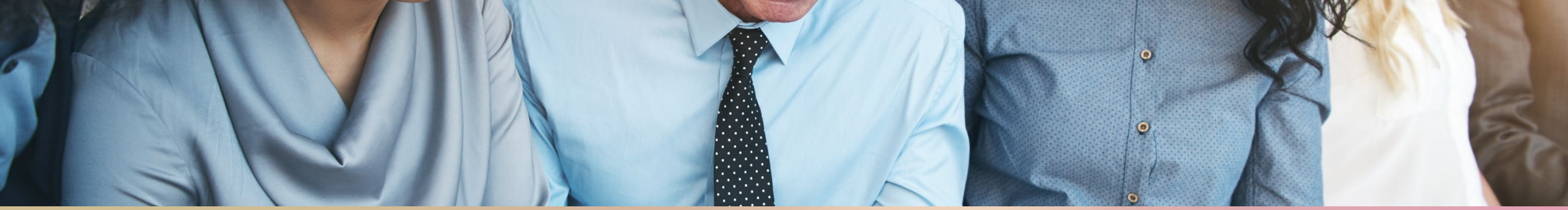
- Many times a claim will be denied, with the presumption that a dispute as to AOE/COE will yield a better result on overall money paid out on the claim. This is not always the case, and therefore the decision to admit or deny liability must be evaluated on a case by case basis.
- Often, maintaining a weak denial can result in far more expenditure in comparison with the claim being admitted.
- The reason weak denials cost employers/carriers more money in the long run are because medical control, MPN's, and utilization review cannot be utilized to control the costs of the claim.

Medical Control, MPN, UR

- Admitted versus denied claims
  - MPN (Medical Provider Network)- In admitted cases, Applicant's are forced to treat within the medical provider network. Just as Applicant oriented lien treaters know how to "play the game" by increasing indemnity exposure, MPN treating physicians also know how to "play the game" on the defense side.
    - It all comes down to money. Lien treaters on denied cases increase their likelihood and value of payment by rendering opinions that increase the costs of treatment and indemnity.
    - Conversely, if MPN doctor's fail to control treatment through conservative measures and through pre-negotiated rates, they are unlikely to receive additional business, and may be kicked out of the MPN
  - UR- Utilization Review now determines the reasonableness and necessity of treatment. All treatment recommendations must be submitted through a request for authorization, which may be certified, denied, or amended by utilization review. This helps limit and/or preclude treatment from rogue doctors within the MPN, or treatment that would otherwise be determined as excessive

Medical Control, MPN, UR (Strategic Considerations)

- Maintaining medical control by using the MPN, and controlling medical treatment through utilization review are excellent tools to limit overall exposure on a case.
- Because MPN and UR can only be utilized on admitted cases, careful analysis must take place to determine whether it is best to maintain a denial or admit liability for the claim.
- Where a denial is “weak”, or causation can easily be found through proper medical reporting, continuing to maintain a denial will often times cost you more money in the long run. Why?
  - Retro temporary disability
  - EDD liens
  - Medical treatment liens
  - No medical control and lack of conservative reporting
  - Always remember CCR 10109



Choice of Doctor/Compensability Exams

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- LC 4616
  - (a)1- An insurer, employer or entity that provides physician network services may establish or modify a medical provider network for the provision of medical treatment to injured employees…
  - (2)- Medical treatment for injuries shall be readily available at reasonable times to all employees…
- LC 4616.3
  - (a) When the injured employee notifies the employer of the injury or files a claim for workers' compensation with the employer, the employer shall arrange an initial medical evaluation and begin treatment as required by Section 4600.
  - (b) The employer shall notify the employee of his or her right to be treated by a physician of his or her choice after the first visit from the medical provider network.

Choice of Doctor/Compensability Exams

- LC 4050- Whenever the right to compensation under this division exists in favor of an employee, he shall, upon the written request of his employer, submit at reasonable intervals to examination by a practicing physician, provided and paid for by the employer…
- LC 4060- This section applies to disputes over the compensability of any injury, and allows either party, at any time, to request a comprehensive medical evaluation.
- LC 5402(c)- an injured worker is entitled to up to $10,000 in medical benefits when compensability of a claim is on delay and/or under investigation, until the claim has been accepted or denied.

Choice of Doctor/Compensability Exams (Practical Considerations)

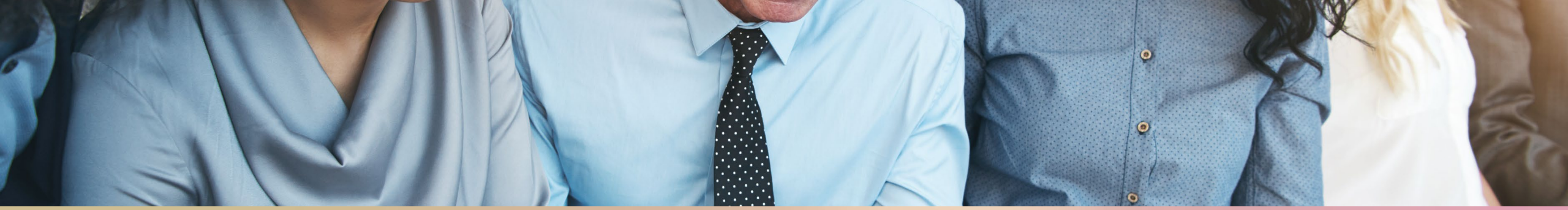
- Upon being provided notice of an alleged injury, the employer has the right, and shall schedule an appointment within the medical provider network. However, after the first visit, the employee has the right to select their own doctor within the MPN.
  - Since we are required to schedule an appointment, and pay up to $10,000 in medical prior to a compensability determination, consider choosing the most conservative and comprehensive doctor for the evaluation. If you are unfamiliar with the doctor's in your MPN, consider talking to your claims administrator, attorney, or medical access assistant.
- Furthermore, LC 4050 states the worker must attend examinations that are scheduled and paid for by the employer.

Choice of Doctor/Compensability Exams (Practical Considerations)

- LC 4060 exams are examinations to determine compensability, but the process is handled in the same manner as a request for PQME panel. Thus, while this option gives the employer a quick opportunity to evaluate compensability, you are not guaranteed to get a good conservative doctor.
- Takeaways:
  - Rather than rush to a quick denial, or sit on your hands after notice of an injury, consider taking the time to find a doctor, of your choosing, to render an initial comprehensive opinion within the MPN.
  - Understand that many MPN treaters do not know how to perform or write a comprehensive medical report to meet the standards of substantial medical evidence. If this situation occurs, the court is almost certain to rely upon the med-legal PQME report. Thus, it is worthwhile to take the time to schedule the initial evaluation with a good doctor.

Choice of Doctor/Compensability Exams (Practical Considerations)

- Takeaways
  - By doing nothing, or rushing to a quick denial, you may lose out on your opportunity to procure good initial medical reporting from a doctor of your choosing. This can also be a good tool to help for early, reduced value settlement.
  - Good initial reporting can help fight credibility issues and alleged nature and extent of the injury. Especially in litigated cases, Applicant's will tend to add additional body parts/body systems after retaining an attorney or as the case prolongs. If an Applicant makes additional allegations subsequent to the initial evaluation, you have a better chance at attacking those additional allegations.



PQME Process and the Impact of Additional Panels

PQME Process and the Impact of Additional Panels

- What is the PQME process and what is it designed to do?
  - Panel Qualified Medical Evaluators are certified and licensed doctors through the California Division of Workers' Compensation Medical Unit, who resolve medical disputes.
  - PQME's do not resolve factual disputes, nor do they have the authority to do so.
  - LC 4062(a) "If either the employee or employer objects to a medical determination made by the treating physician concerning any medical issues not covered by Section 4060 (AOE/COE compensability) or 4061 (PD) and not subject to Section 4610 (UR) the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report…"
  - Thereafter the DWC will issue a list of 3 doctors to choose from who are within the requested medical specialty
    - Non Litigated- Applicant gets to choose the doctor.
    - Litigated- Each party gets to strike a doctor and you proceed with the doctor that is left.

PQME Process and the Impact of Additional Panels

- Why are additional PQME panels hurtful to the defense of a claim?
  - The costs of each PQME evaluation can be expensive, especially in cases with voluminous records. Currently, a PQME evaluation costs $2,015.00 and includes review of only 200 pages. Each page over 200 is paid at $3.00 per page.
    - 1000 pages brings the report cost to $4,415.00
    - 2000 pages brings the report cost to $7,415.00
  - PQME's may only comment on allegations within their specialty. Thus, if the allegations encompass multiple body parts/body systems, you may be faced with having to procure multiple PQME evaluations in each specialty.
  - There is a general suspicion that applicant's attorneys are going on unwarranted fishing expeditions when requesting additional QME panels, particularly when the alleged injuries appear superfluous or described as "skin and contents".

PQME Process and the Impact of Additional Panels

- Why are additional PQME panels hurtful to the defense of a claim?
  - Each PQME specialty increases permanent disability, temporary disability, and medical treatment exposure, and can increase litigation costs if the reporting needs to be challenged or supplemented.
  - It becomes increasingly difficult to challenge allegations over disputed body parts when there is a finding of a PQME as to compensability.
  - While it shouldn't, PQME opinions can also make it more difficult to challenge factual disputes, despite the fact they are only there to resolve medical disputes.

PQME Process and the Impact of Additional Panels

- What are strategies to defend against additional PQME specialty requests?
  - PQME's only occur when there is a medical dispute. In order to create a dispute, there must first be a medical treatment report commenting on the alleged body parts/body systems. Thus, without any medical, there is nothing to dispute.
  - Some liberal WCAB judges take the position that allegations and pleadings are enough to create a medical dispute for which a PQME is required. This is incorrect under the law and must be challenged by your attorney. According to the PQME panel request procedures outlined under LC 4061/4062, the disputing party must issue an objection to a treating physician and request a panel thereafter.
  - It is key to assert that without any medical evidence, there can be no dispute requiring a PQME.

PQME Process and the Impact of Additional Panels

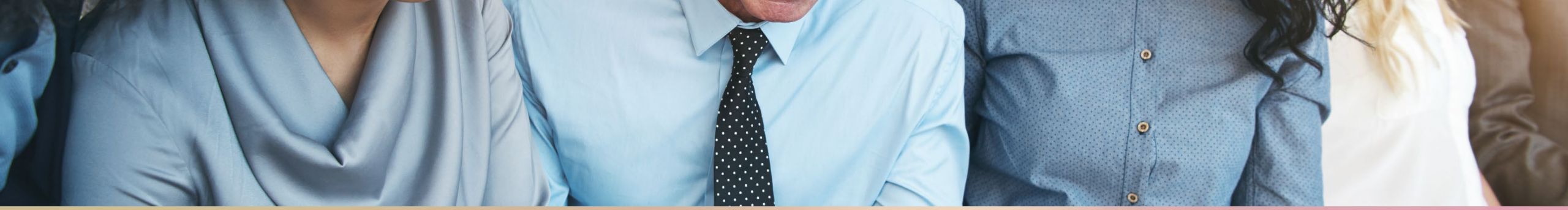
- What are strategies to defend against additional PQME specialty requests?
  - Another problem with denied cases is the inability to maintain medical control. Thus, Applicant's are allowed to treat with doctors of their choosing, typically at the instruction of their attorney who is familiar or has a relationship with the doctor. This makes it easier for the Applicant to receive medical reports commenting on the full extent of their allegations, which most often are very liberal in their diagnosis. Unfortunately, if medical reporting has been procured, our only option to dispute the medical is by engaging the PQME process.
  - Consider using your MPN to your advantage to control the extent of created medical disputes.
  - Typically, MPN doctors are much less likely to comment on body parts/party systems deemed unreasonable and superfluous.

PQME Process and the Impact of Additional Panels

- What are strategies to defend against additional PQME specialty requests?
  - Since MPN treatment only occurs on admitted cases, the utilization review process also applies.
  - If a MPN doctor believes a consultation in another specialty is warranted, he must submit a request for authorization for the consultation, which could be denied by utilization review. This gives us another opportunity to argue that the additional specialty, either in the form of a consultation or PQME, has been deemed unreasonable and unnecessary.
  - Applicant's attorneys will often use a PQME's opinion to create a medical dispute requiring an additional panel. Examples typically occur during a cross examination of the PQME, or having the PQME comment on the need for consultation/evaluation in other areas outside of his specialty.

PQME Process and the Impact of Additional Panels

- What are strategies to defend against additional PQME specialty requests?
  - Rule #1- Medical disputes according to LC 4061/4062 must come from a treating physician.
    - It doesn't matter what a PQME thinks
  - Rule #2- If a PQME says there is a need for a consultation, and the consultation is required to resolve a medical dispute, consider having the consultation performed by an MPN doctor versus acquiescing to a PQME panel in that specialty.
    - The costs of the consultation will be significantly lower than a PQME, and you are more likely to receive a conservative or no causation report.
  - Rule #3- PQME's do not create the medical dispute, they are there to resolve the medical dispute.



Going to Court and Development of the Record

Going to Court and Development of the Record

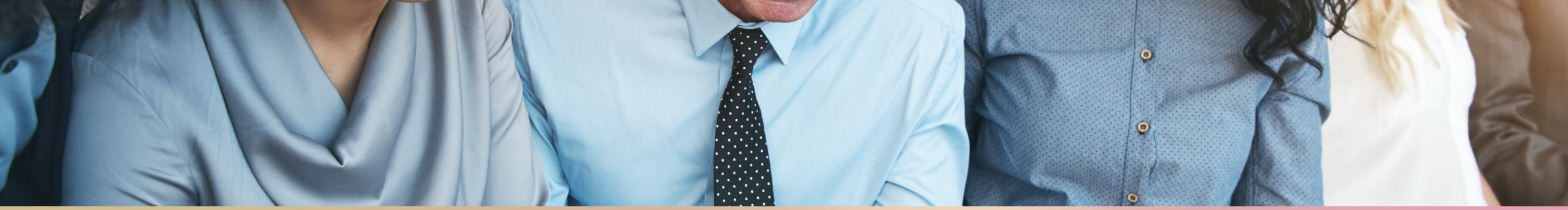
- Understand that workers' compensation is NOT an even playing field.
- The system is designed to be a benefit providing system to injured workers. While the system is not fair, the exclusive remedy of workers' compensation precludes separate causes of action against employers, absent very few exceptions.
- LC 3202- This division and Division 5 (commencing with Section 6300) shall be liberally construed by the courts with the purpose of extending their benefits for the protection of persons injured in the course of their employment.

Going to Court and Development of the Record

- A series of recent cases have come down that have highlighted inefficiencies of the WCAB. These cases primarily dealt the Appeals Board inability to address appeals (petitions for reconsideration) on a timely basis, and with required specificity to determine the court's rationale for denying or granting reconsideration.
- The WCAB has long been granted the power to further develop the record, pursuant to LC 5701, LC 5906, applicable case law, and to "accomplish substantial justice in all cases expeditiously, inexpensively, and without incumbrance of any character...." (Cal. Const., art. XIV, § 4.)
- Moreover, case law supports the WCAB's right to further develop the record, not only at the trial level, but also at the MSC level.

Going to Court and Development of the Record

- So what does this all mean?
  - The Appeals Board-Recon Unit has been increasingly remanding back to the trial level for "further development of the record." This provides an easy way out for the Appeals Board to respond to petitions for reconsideration, in a system they have already been deemed to be inefficient.
  - Trial level judge's before the WCAB take on increased work load for every petition for reconsideration that is filed or granted. Trial judge's must respond to the petition for reconsideration, and if reconsideration is granted by the Appeals Board, the trial judge may be faced with more work of trying the case again, or developing the record.
  - For these reasons, trial judges are erring more on the side of caution by ensuring the record is perfected before deciding to try the case.
  - Most often, further development of the record requires additional medical reporting or PQME panels.



Settlements- Return to Work and Resignations

Settlements- Return to Work and Resignations

- Workers' Compensation has two methods for resolving claims.
  - Stipulated Award- Resolves all indemnity benefits, but leaves the right to future medical care open for life.
  - Compromise and Release- Resolves all indemnity benefits and future medical care.
- There is a general custom and practice understood by both sides when it comes to settling a case either by Stipulated Award or Compromise and Release. Specifically, Stipulated Awards will mostly occur when the Applicant continues to work for the insured, and Compromise and Release will mostly occur when the Applicant no longer works for the insured or agrees to voluntarily resign as part of the settlement.

Settlements- Return to Work and Resignations

- Why?
  - All settlements must be evaluated for their adequacy prior to approval. In cases where the parties decide to resolve by compromise and release, a judge will have to determine whether the amount of the settlement adequately compensates the Applicant for benefits owed, including the anticipated costs of lifetime future medical care.
  - Example: Applicant sustained an admitted low back injury. Although permanent and stationary, Applicant will likely need surgery in the future. The costs of the surgery is estimated at $25,000.00. In a judge's review of settlement adequacy, they will want to ensure Applicant is paid for any remaining temporary disability, permanent disability, with an additional $25,000.00.

Settlements- Return to Work and Resignations

- Why?
  - Example- Using the same scenario, let's say the compromise and release was approved while Applicant was still employed with the insured. Although Applicant's claim is resolved and closed, he sustains another injury to his back a week later. This new injury to the back is also admitted, and once again, it is determined Applicant will need back surgery in the future estimated at $25,000.00.
  - In order for this new injury to be resolved by compromise and release, the Applicant will need an additional $25,000.00 for the costs of the anticipated surgery. While the need for surgery was present after the original injury, the new settlement must also include the costs of surgery. Applicant has now essentially doubled his recovery for the costs of surgery.

Settlements- Return to Work and Resignations

- Why?
  - The example provided illustrates why a compromise and release settlement is not preferred in situations where the Applicant is still employed. Most employers/carriers want to avoid an Applicant's duplicative recovery.
  - Applicant's attorney's are well aware of the dilemma this puts the employers and carriers in, and for that reason, they typically understand a case cannot be settled by compromise and release while the Applicant is still employed.
  - Since Applicant's attorney recovers their attorney fee based upon the total value of settlement, and because compromise and release settlement are higher value due to the buy out of future medical care, they too are incentivized to resolve the case by compromise and release.

Settlements- Return to Work and Resignations

- Employers are faced with a difficult dilemma in determining whether to allow an Applicant to return to work, or require a resignation in conjunction with a settlement.
- Understand that every workers' compensation claim involves a claim of disability. Therefore, every workers' compensation claim provides a nexus to potential disability discrimination. Disability discrimination is a separate cause of action that can be pursued in civil court.
- It is unlawful to discriminate or take adverse action against an employee who has or alleges a form of disability.
- A question arises as to whether an employer who requires voluntary resignation as part of a compromise and release constitutes adverse action/disability discrimination. Not only could this allegation apply to the specific applicant, but it might also apply to a class action lawsuit.

Settlements- Return to Work and Resignations

- Homeport Ins. Servs., Inc. v. Lundy
  - Lundy was a longshoreman at the Port of Long Beach who had filed a personal injury claim and workers' compensation claim. As part of settlement, Lundy was required to sign a "no reemployment" provision. Thereafter, Lundy was found to be working at the Port of Long Beach after being dispatched. Port of Long Beach then sought enforcement of the settlement contract and injunctive relief.
  - Lundy argued the "no reemployment provision" was unenforceable and in violation of LC 132a.
  - The court found that the provision could constitute unlawful discrimination or retaliation, but that Lundy failed to prove that the provision was done in a discriminatory or retaliatory reason.
  - They noted how the settlement had been mutually negotiated between represented parties and did not have a uniform practice or requiring "no reemployment" for all of its claims.

Settlements- Return to Work and Resignations

- Golden v. California Emergency Physicians Medical Group
  - Golden was a doctor who settled a lawsuit with his employer. As part of the settlement, the medical group required termination of Golden's employment. Golden refused so sign, and litigation ensued to determine whether the employment provision was in violation of California's ban on non-competition clauses. Golden's argument was based upon the Medical Group's size and reach throughout California.
  - The court found the provision unenforceable. Although the ruling did not prohibit employers from conditioning a settlement agreement upon an employee's resignation, provided that such a condition does not somehow restrain the employee's future practice in the same field. Nonetheless, employers – especially larger employers or those with a large market share in a geographic region – should be prudent when drafting "no future employment" provisions of settlement agreements with current and former employees

Settlements- Return to Work and Resignations

- Final Takeaways
  - Every case, including the decision to request resignation as part of settlement, needs to be evaluated on a case by case basis.
  - In our opinion, voluntary resignations should be avoided as they present too much liability exposure and open the door to disability discrimination causes of action.
  - If voluntary resignation is required by the employer/carrier, efforts should be made to ensure the policy is not uniform, across the board, and on every case.
  - Carefully crafted language in a settlement can essentially indicate an agreement by the parties to end the employment relationship as part of settlement, buy reducing the risk that could ensure from a practice of requiring voluntary resignations.

QUESTIONS?

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THANK YOU

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