WORKERS' COMPENSATION QUARTERLY

Workers' Compensation Section of The State Bar of California *Vol. 25, No. 4 2013*

Understanding Social Security Disability Offsets: Aiding Your Clients and Avoiding Malpractice

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When a claimant is a recipient of social security disability benefits and also receives workers' compensation benefits or state disability payments, the claimant's social security disability benefits may be reduced or offset (42 U.S.C. § 424(a), 20 C.F.R. § 404.408). This article discusses calculation of the offset and strategies that can be used to minimize the offset, maximize the net recovery to the claimant, and avoid potential malpractice.

The determination of whether social security disability benefits are reduced because of these payments depends on a variety of factors and calculations. The standard of care requires you, as an attorney practicing in this field of law, to be familiar with these factors and advise your clients who may be affected. It is important to know, when settling a workers' compensation claim resulting in one or more lump-sum payments, that you may add language to the Compromise and Release (C&R) that can modify and often eliminate the social security disability offset. Failure to consider this issue is akin to playing Russian roulette with the claimant's economic future. Of course, in the majority of situations either your client will not be receiving social security disability benefits or the offset provisions will not reduce their benefits. However, you may occasionally have a client for whom the offset issue arises, and you need to be prepared to identify and minimize that offset.

When a claimant receives both workers' compensation benefits and social security disability benefits, it is possible for the combined benefits to exceed the amount of the wages the claimant earned before becoming disabled. To avoid this anomaly the Social Security Act places a ceiling on an individual's combined benefits. The statute provides that when an individual is receiving both social security disability insurance benefits and either workers' compensation benefits or other public disability benefits, the social security benefits "shall be reduced" by the amount necessary to ensure that the sum of the state and federal benefits does not exceed 80 percent of the individual's pre-disability average current earnings (42 U.S.C. § 424(a); 20 C.F.F. § 404.408). Doing so prevents the duplication of benefits inherent in the programs, thus eliminating the possibility that the claimant will receive more benefits post disability than earnings received before being disabled.

INSIDE:

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Calculating the Offset

Social security calculates the offset by considering three factors:

- The claimant's highest annual earnings, also referred to as the average current earnings
- The claimant's monthly workers' compensation benefit
- The claimant's monthly social security disability benefit

As mentioned earlier, the combined workers' compensation benefit and social security disability benefit cannot exceed 80 percent of the claimant's highest annual earnings. To determine the highest annual earnings, the Social Security Administration (SSA) predominantly uses the higher dollar figure of the following two calculations:

- The highest annual earnings during a period including the calendar year in which the disability occurred as well as the five years immediately preceding the year of disability
- The average earnings of any five consecutive years during the claimant's work life prior to the disability

To illustrate the calculation of the offset, suppose a construction worker is injured on the job. His highest annual earnings in 2006, three years before his disabling injury, was $30,000, calculated using the methods described above. He was 53 when he was injured in July of 2009 and turned 55 in January of 2011. In July of 2011 he exhausted his two years of temporary disability payments. The worker's average weekly wage as calculated by California Labor Code section 4453 was $400. He was granted social security disability benefits in December of 2011, retroactive to his 55th birthday. His monthly social security disability benefit, also known as the Primary Insurance Amount (PIA), is $1,500 per month. In February of 2012 he became permanent and stationary and received permanent disability advances of $230 per week until his claim was settled. An Order approving the C&R was entered in July of 2012.

The following list illustrates the process for calculating the worker's offset.

1. The California partial permanent disability benefit is $230 per week, or $989 per month ($230 × 4.3 weeks/month = $989).
2. Prior highest annual earnings are $30,000.
3. 80 percent of the highest annual earnings is $24,000, or $2,000 per month ($30,000 × 80% = $24,000 ÷ 12 = $2,000).
4. The monthly social security Primary Insurance Amount is $1,500.
5. The monthly workers' compensation benefit subtracted from 80 percent of the highest annual earnings is $1,011 ($2,000 – $989 = $1,011). The $1,011 represent the maximum social security disability benefit SSA can pay, given the current monthly workers' compensation benefit.
6. The social security offset is $489 ($1,500(PIA) – $1,011 = $489).

In the example, $2,000 is the 80 percent maximum the claimant can receive, combining state workers' compensation and federal social security benefits. The monthly permanent disability payments are $989 per month, leaving only $1,011 in social security benefits before payments reach the 80 percent maximum of $2,000. This scenario requires social security to reduce the monthly benefits, which would otherwise be $1,500 a month, to a significantly reduced $1,011 a month. This is a loss of $489 per month, with an annualized loss of $5,868.

Assume the injured worker in this scenario is your client. Being a seasoned veteran in workers' compensation law, you expertly negotiate a very favorable C&R, resulting in a permanent disability lump-sum payment of $100,000 after excludable expenses (which are discussed later in this article). The SSA will use the permanent disability rate to amortize the claimant's lump-sum payment. At the permanent disability rate of $230 per week, it will take approximately 418 weeks, or about eight years, to amortize your client's lump-sum payment.

Two months after the ink dries on the C&R, your client calls you to ask why his social security benefits were reduced from $1,500 to $1,011. At this point it is too late to minimize the impact of the workers' compensation offset. Your client is now losing $489 a month, or $5,868 a year. The offset will continue for eight years, until the C&R is fully amortized. This results in a grand total of $46,944 in unnecessarily lost social security benefits. For an injured worker earning $30,000 before his disability, the loss of $46,944 over eight years is devastating. Who is responsible for that loss? This author submits that attorneys who do not consider the effects of the offset on their clients have failed to fulfill their professional responsibilities to represent those clients and may be subject to legal malpractice claims.

Minimizing the Offset

What can be done to avoid or minimize these reductions in benefits? Before addressing that issue, we should look at what is not included in the calculation of the offset: third-party settlements, unemployment compensation benefits, Veterans Affairs benefits, Jones Act benefits, private pension benefits, and long-term disability benefits. However, any workers' compensation payments and state disability payments are an offset even if the social security disability benefits were awarded based on a non-work, completely unrelated disability.

If the claimant's workers' compensation case goes to trial, there is obviously no opportunity for planning; the SSA will simply determine the offset using the permanent disability

rate expressed in the award and as calculated earlier in this article. However, if the matter is resolved by agreement, the settlement documents can be used to reduce or eliminate the offset by excluding certain fees and expenses from the workers' compensation payments and spreading the lump-sum settlement over the life expectancy or work-life expectancy of the claimant.

The first step is to ascertain how much of the lump sum social security will use in calculating the offset. From the gross amount of the C&R, the SSA will allow you to deduct "excludable expenses" to arrive at the lump-sum amount that will be amortized and used as an offset. The SSA's Program Operations Manual System (POMS) section DI 52120.030 defines "excludable expenses" and permits the reduction of the following expenses from the gross amount of the C&R:

- Approved legal fees.
- Allocated medical expenses identified in the C&R.
- Penalties paid in the C&R.
- Monies allocated for a Medicare Set Aside Trust.
- Amounts allocated to purchase annuities or structured settlements. However, the SSA will use any future annuity payments in the structure to calculate any future offsets when actually received. Any future lump-sum payments in the structure may be amortized over the claimant's life expectancy in the same manner as the original lump sum in the C&R.
- Liens for legal or medical expenses paid from the lump sum and deducted from the claimant's share.
- Lump-sum catch-up payments for unpaid temporary disability benefits when included in the gross award.
- Supplemental Job Displacement Benefits (SJDBs) are excludable since the payment is issued directly to the educational retraining or skill enhancement school. However, if all or part of the SJDB benefit is paid directly to the claimant, the amount the claimant receives is not excludable.

Note that permanent disability advances paid to the claimant prior to the date of the C&R are not excludable from the lump sum.

Once excludable expenses have reduced the C&R, the net amount to the claimant is amortized by a weekly rate. The methods for establishing weekly rates, as set forth in the Administration's Program Operational Manual, in descending order of priority, are as follows:

1. The rate specified in the lump-sum award.
2. The periodic rate paid prior to the lump sum.
3. The maximum permanent partial rate in California if no prior permanent disability payments have been made. Note that if the claimant received permanent disability advances, the SSA will use the PDA rate to amortize the lump sum absent any other direction (Social Security Ruling 87-21c).

The SSA looks first to the C&R for guidance on the amortization of the lump sum. The SSA is, in effect, inviting the practitioner to create a more favorable offset provision for the claimant. Failure to do so will simply result in the Administration's using the permanent disability rate in effect for the claimant's date of injury. The SSA will apply the offset for any month in which the claimant was entitled to both social security disability benefits and workers' compensation benefits and will continue applying the offset until the claimant reaches age 65 or the lump sum is fully amortized using the permanent disability rate.

As discussed earlier in this article, the result may be a significant offset to the social security benefits, with lower wage earners being hit the hardest. This occurs because the lower wage earner has a lower 80 percent maximum and therefore a proportionately higher offset. Higher wage earners, such as those earning $100,000, are usually not affected by the offset since they can receive a combined 80 percent, or $80,000, in combined benefits. The SSA will allow the claimant to amortize the lump sum favorably, but if this issue is not addressed in the original settlement documents, the Administration will not allow a subsequent stipulation or award that attempts to reduce the offset (Social Security Ruling 87-21c; POMS § DI52150.065e). There is no "do-over," which is why it is so important to address the offset issue correctly in the original C&R.

Obviously, the greater the number of years over which the lump sum can be spread, the lower the monthly amortization number will be and the lower the social security offset will be. At one point there was a split among social security practitioners as to whether the settlement award may be spread over the claimant's life expectancy or over the claimant's work life expectancy. In *Hodge v. Shalala* 27 F.3rd 430 (9th Cir.1994), the Court determined that under Oregon's workers' compensation law, a lump-sum payment is a substitute for a stream of payments for the remainder of an individual's working life, which the court presumed to end at age 65 (see also Acquiescence Ruling 95-2(9)).

However, the SSA subsequently issued POMS section 52150.065, effective February 22, 2011, in which the SSA specifically recognizes that a lump-sum award may specify a payment amount based on the claimant's life expectancy determined by insurance life expectancy tables and provides guidelines for doing so. (POMS section 52120.030, effective September 19, 2011, addresses the offset provisions specific to California workers' compensation claims.) POMS section 52121.030 indicates that the SSA is not bound by any specific formula, such as the Hartman formula identified in the C&R, to amortize a lump sum. However, that POMS section refers back to POMS section 52150.065, which does allow a lifetime amortization using the guidelines set out therein. In California, therefore, the lump sum should be spread over the course of the claimant's life expectancy. Doing so greatly reduces any

social security offset and in most circumstances completely eliminates the potential offset.

Amortization of the Lump Sum

Three factors determine the correct amortization of the lump sum:

- The lump sum amount after deduction for allowable excludable expenses
- The beginning of the amortization period
- The claimant's life expectancy

The beginning of the amortization period is the day after the last payment of temporary disability payments was made. If no temporary disability payments were made, the amortization period begins on the date of the injury or the last date the claimant worked in the industry (POMS § DI52120.030). The life expectancy can be determined by referring to life expectancy tables. The Centers for Disease Control has published these tables, which can be referenced as the National Vital Statistics Report, Vol. 58, No. 21, June 28, 2010.

The claimant in the example at the beginning of this article turned 55 prior to the date of his last temporary disability payment of $400 in July of 2011. His life expectancy is 24.7 years. His last temporary disability payment of $400 occurred in July of 2011, when he was 55. His lump-sum payment, received in July of 2012, was $100,000.

Following is an analysis of the calculations for this claimant in determining amortization of the lump sum:

1. The amortization period begins at age 55.
2. The lump sum after excludable expenses is $100,000.
3. Life expectancy is 24.7 years, or 296.4 months (24.7 × 12 = 296.4).
4. The monthly payment amortized over the life expectancy is $337.38 ($100,000 ÷ 296.4 = $337.38).

We know that 80 percent of the average current earning is $2,000. Instead of using the permanent disability rate of $230 per week, or $989 per month, as an offset, we are able to use the much more favorable weekly amount of $337.38. Instead of our initial calculation of $2,000 – $989 = $1,011, we are now permitted to use the favorable calculation of $2,000 – 337.38 = $1,662. The latter amount is what the claimant would be permitted to receive in social security benefits and still remain under the 80 percent cap. Since the claimant's social security benefit rate is $1,500 per month, he is under the 80 percent cap and there is no offset. By including language in the C&R amortizing the lump sum over his life expectancy, we have legally eliminated the social security offset and increased the claimant's combined state and federal benefits by $5,868 per year, for a total of $46,944 over the life of the C&R.

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Filing/Activation Fees, and a Warning to Defendants

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Legislation effective January 1, 2013, requires medical treatment providers to pay a $150 lien filing fee for a new lien. It also requires medical and certain other providers who filed liens prior to 2013 to pay a $100 lien activation fee at the earliest of (1) filing a Declaration of Readiness to Proceed (DOR), (2) before attending a lien conference, or (3) December 31, 2013. Labor Code sections 4903.05 and 4903.06; 8 CCR section 10208. The consequence of failure to submit proof of payment when filing a DOR is that the DOR will be rejected and not processed, and the consequence of failure to pay the activation fee by the time of a lien conference or January 1, 2014, whichever is earlier, is dismissal of the lien with prejudice.

While judges have information available to them, via EAMS and the EAMS public access website, documenting whether or not the lien filing fee or lien activation fee has been paid, Labor Code section 4903.06(a)(4) specifically states that lien claimants that did not file the DOR must submit at the lien conference proof of payment of the activation fees. Do not assume that a judge will take the time to look in EAMS

to see whether the activation fee has been paid. It would be prudent, to avoid any confusion or misunderstanding, for all lien claimants, including the one that filed the DOR, to have proof of payment of the fee at the time of the lien conference.

The WCAB has proposed regulations that are currently pending in the regular rulemaking process and not yet in effect that will expand the types of appearances at which a legacy (pre-2013) lien claimant must pay the activation fee. For now, an activation or filing fee is not required for appearances at status conferences, mandatory settlement conferences, pretrial conferences, expedited hearings, rating MSCs, trials on case-in-chief issues, or at lien trials when the lien conference occurred prior to 2013. Practitioners need to be aware that if a lien claimant is a *party* as defined by 8 CCR section 10301(x)(3), pursuant to 8 CCR section 10770.1(a) and (c), any type of hearing that is set is to be construed as a *lien conference*, before which payment of the activation fee will be required.

Labor Code section 4903.07 specifies a procedure for a lien claimant to recover the activation or filing fee from defendant. Prior to payment of the fee, the lien claimant must make a dollar-specific written demand, and defendant has 20 days to respond in writing. If settlement does not result and the lien claimant still wishes to pursue its lien balance, the lien claimant must pay the activation or filing fee. Certainly this must be done on legacy liens before filing a DOR to have the lien adjudicated before the WCAB or before December 31, 2013. If the final determination of the WCAB is that defendant owes an amount equal to or greater than the demanded amount, defendant is liable for reimbursement of the amount plus the fee.

Unfortunately, the drafters of the legislation did not specify any mechanism for lien claimants to recover the fee when they receive a notice of hearing for a lien conference when they did not file the DOR. It is likely that regulations will be proposed to fill the gaps. Until then, lien claimants should make written settlement demands as soon as they receive a notice of hearing for a lien conference (or any type of hearing) and specifically request the WCAB to award reimbursement of the fee under Labor Code section 5811 if the demanded amount is found reasonable.

The rationale of the legislation is to encourage parties to resolve outstanding liens before the jurisdiction of the WCAB needs to be invoked. However, several claims adjusters and defense attorneys are demanding that lien claimants produce proof of payment of the filing or activation fee as a precondition to lien negotiation. The tactic is contrary to the spirit of the law, which mandates that lien claimants attempt negotiation of the liens prior to filing DORs or appearing at lien conferences. On legacy liens, payment of the activation fee is not required until a lien claimant files the DOR or, if the lien claimant did not file the DOR, prior to appearance at a lien conference. Labor Code section 4903.06(a)(4). For services provided in 2013 and beyond, lien filing is not required to initiate settlement discussions.

Both defendants and lien claimants are required to engage in good-faith negotiations. Filing a DOR requires a statement under penalty of perjury of the "specific, genuine, good faith efforts to resolve the dispute(s)." Failure to comply results in taxing the time and resources of the WCAB to resolve lien disputes and circumvents the assumed purpose of the law, which is to encourage lien resolution prior to setting hearings on the WCAB calendars.

Workers' compensation judges will have ample justification to grant a petition filed by a lien claimant requesting sanctions, attorney fees, and costs for bad-faith actions or tactics when defendant insists on proof of activation- or filing-fee payment before negotiating.

Observe that non-attorney lien claimants may request and be awarded attorney fees: under Labor Code sections 4907 and 5813 and 8 CCR section 10561, anyone who appears at the WCAB is subject to an assessment or award of attorney fees (although someone who is not a member of the State Bar likely will be awarded a lesser hourly fee). Note that 8 CCR section 10561(e) specifically states:

> Notwithstanding any other provision of these rules, for purposes of this rule and Labor Code section 5813: (1) a lien claimant may be deemed a *party* at any stage of the proceedings before the Workers' Compensation Appeals Board; and (2) an *attorney* includes a lay representative of a party or lien claimant.

Prudent lien claimants that find themselves in the position in which claims adjusters or defense attorneys are refusing to negotiate liens prior to proof of payment of a lien activation or filing fee will be collecting or documenting proof of defendants' refusal to negotiate and may soon be filing petitions on the issue. Since lien claimants are considered a party at any stage of the proceedings for purposes of Labor Code section 5813 and 8 CCR section 10561, there is nothing to prevent them from filing such a petition before paying an activation or filing fee. To capture the attention of the judges, lien claimants should clearly reference 8 CCR section 10561(e) in their pleadings.

It may take a few well-publicized cases where sanctions, costs, and attorney fees were assessed, or maybe a DWC Newsline press release by the Administrative Director, to extinguish the tactic of using the activation or filing fee as a precondition to lien negotiation. Defendants would be well advised to abandon the tactic now.

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Confessions of a Shopaholic: Hand Over Those Manolo Blahnik Heels and Nobody Gets Hurt–A WCJ's Rant on Proper Court Attire

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Writer's comment: These satirical musings are the opinion of the writer alone and do not represent the opinion or policy of the Department of Industrial Relations, the Division of Workers' Compensation, the Workers' Compensation Appeals Board, other judges, or staff.

It's hard to be a Californian. The fashion mecca of New York beckons, and sample sales elude us California girls and guys. Oh, the "Sample Sale." Sigh. I signed up years ago for e-mail blasts of all the New York sample sales, and in the days when you could get a fare on Jet Blue for $129 to JFK… okay, but I digress. For those of us who have lived south of the Tehachapis, in the promised land of beautiful weather, tanned bodies, and botox for days, the fashion police are also out in full force. The "fashionista creep," as I call it, doesn't spare us in the north, even for this NorCal transplant/returnee.

I know that a lot of judges, attorneys, and hearing and lien reps who appear at the "Board" (yay! It's a "Board" again; I was beginning to wonder just what we were, for a while, there) forget that where we do our work is, in fact, a court. Our looks range from the "just rolled out of bed" to "as soon as I'm done here, I'm hitting the nightclub." Just what am I getting at? Aside from having an actual written policy on appropriate dress at the "Board" (you can say it…"Board"; you know you want to), we judges are reluctant to point out, shall I say, the fashion faux pas or outright travesties in the interpretation of appropriate dress for court.

My personal debate ranges from, "We are dealing with adults who are capable of deciding what is appropriate to wear for court" to, "What do they think this is, Hollywood Boulevard on Saturday night?"

I'm not just talking about the ladies. Some of you men out there consider your fashion idol to be Rico Suave. The gold-chain, medallion, and open-shirt look is better shared after 5:00 p.m. at your favorite club. Why do you wear cologne as if you're an elk calling your mate? Also, anything produced by Faberge went out with Joe Namath. That should tell you how long it's been out of style. And no need to bathe in the stuff. Tone it down a little, would you? We shouldn't have to smell it even after the elevator door closes on you, or worse, before the door even opens.

That also goes for you smokers. Yikes, why do we have to breathe that stuff too? Air yourselves out before entering the building. Another gripe: BrylCreem, or any of the various ways some of you guys plaster your hair Sopranos-style. Really? My dad wore that in the '70s, and even *then* it was passé. Ulta has great hair products for men that don't involve shellac. See Rico Suave, *supra*. Check it out.

As for the rumpled, 5:00 o'clock shadow look? Only after 5:00. Be nicely groomed at 8:30 a.m., please. An iron is an inexpensive way to keep your clothes pressed, or take your suits to the dry cleaners. Something. Rumpled only works for Johnny Depp, and that's only when he's in Jack Sparrow mode.

I do have to give props to you stylish men who don't try to hide the fact that Mother Nature is playing with your hairline. What a cruel hand of fate! But some of you gentlemen understand the rule of Telly Savalas: bald is sexy, comb-overs are for wimps, and "Who loves you, Baby." Kudos for you! As much as I like The Donald, I don't like the pompadour, and the rest of us feel real pity, or the mean ones just snicker. Be brave and proud, and embrace the real you. Join the Hair Club for Men, or see a plastic surgeon who specializes in hair restoration, if that matters so much to you. I hear there are a few plastic surgeons in California open for business.

The gripes don't extend just to the men. Oh, no, ladies. We are the *worst* offenders in the appropriately dressed and groomed department. Ladies love guidelines (stop guffawing, boys, it's really true—it's just the applicability of rules to a woman's behavior you don't understand). So, here are a few of mine that I like to live by, and maybe some of you ladies will choose to follow them (and class up the joint a bit):

1. Fishnet stockings are for *after* 5:00 p.m. and are *never* to be worn at court. Enough said.

2. "Fire engine" red lipstick is fine, as long as you're wearing red. (Not just a red bag or cell phone case. Your dress or suit also has to be red.) You cannot wear a color on your lips that is less than 50 percent of what you're wearing on your body, *except* for black. Never wear black lipstick. Goth doesn't work for court. (That goes for the fingernails, too).

3. Bare shoulders go with beach blankets, umbrella drinks, and cabanas. Wear a suit jacket over your sleeveless blouse or bustier, or you will be asked to fetch your jacket out of your car to cover up. Who dresses you, Fredericks of Hollywood, or Lady Gaga? Not appropriate for court!

4. Clothes retailers sell more than one size because (this is shocking, I know) we all are different sizes. Don't try to squeeze into a size that you wore in junior high school, especially if you are, shall I say, a "little" bigger than a junior size. It's not flattering, dear. If you're big, be big, beautiful, and proud. And tastefully dressed. This is also true for those of us constantly fighting the scale, and our weight goes up and down like an elevator or hot air balloon: wear clothes that fit. I am guilty of this too. I've recently lost a bit of weight, and my clothes were starting to hang. One of our sweetheart senior legal technicians (SLTs) gently reminded me that "comfy clothes" are for working out or sleeping. If your clothes are big enough to do calisthenics in, it's time to go shopping. American Express is a good thing, and the spending helps the economy. We all have to do our share, right?

5. Ladies, unclad bosoms may get you more in your settlement discussions, but those of you who show them off in court send a vastly different message to the judge and staff. Showing off your cleavage is for a beach, night club, or…enough said. And for those of you who are not happy with this rule, too bad. Not appropriate for court.

6. It's not enough to rant about what happens "topside"; don't forget your hemlines either, ladies. One should be able to sit, cross one's legs, and still have the thighs covered completely. Again, court is not a nightclub. You don't want to be mistaken for a cocktail waitress at the Bellagio. The short-short hems of Ally McBeal are long gone. I think I've made my point. Sorry to disappoint the fellas.

7. Perfume is like another item of clothing, and you shouldn't share it with others. The rule: if someone standing three feet away from you can smell it (that's nearly a *meter*, ladies), you're wearing too much. If someone is standing closer to you than that, call security, or save the interlude until after 5 p.m. Watch the judge. If the judge opens a window or turns on a fan when you walk into his or her office or hearing room, take a cue and tone it down.

I'm not saying any of this because I'm in some sort of elite Michael Kors fan club or because I worship Anna Wintour, the editor of *Vogue* (but I admit, she *is* impeccably dressed). But since I'm a member of the shopaholic club, there has been more than one occasion when a dear friend has barricaded herself outside a designer store to keep me from adding to my purse collection. I think it's called an intervention. Or so I've heard. I may have experience here to impart some tips.

Some last rants: If you need to be late because you've been on a bender (or wild weekend in Vegas), call in and advise you're going to be late. Put yourself together. We don't have to know what you've been imbibing, do we? That raises all sorts of other issues that aren't the subject of this article.

For you ladies, your footwear has become a topic of discussion of late. You wouldn't wear a new evening gown to work, so why wear the stilettos? For you guys, we know tee time is just around the corner, but don't even think of wearing your golf shoes to court. The spikes ruin the carpet, such as it is. I respect the wild and wacky golf attire that quite a few pros like John Daly are wearing these days, but don't wear clothes that make me want to turn down the volume. Or put on sunglasses.

The court attire problem is statewide, as I understand it. It may be a symptom of our ultra-casual California lifestyle we boast about, or we're slaves to the industry that likes to play on our sense of insecurity. No matter the reason, we need to be aware that how we present ourselves professionally makes a difference.

Dress as if you're going to a job interview in the profession you're in rather than an interview at Starbucks or Barnes & Noble. That means ties for men, at a minimum, and preferably a jacket (definitely for trials, anyway). For ladies, you should be wearing a tasteful and professional dress or skirt and blouse, and if the blouse is sleeveless, with a jacket. Suits are never out of style or inappropriate, and they portray you as the professional you are. Impressing the judge goes beyond your legal skill. It involves your entire presentation, and even how you interact with opposing parties (but that is also the subject of another article).

Impress us. Look your best in your efforts to do your best. But you can show off your new Dooney Bourke purse or your butter leather Cole Haan messenger bag or Armani briefcase, and I promise to ooh and ahh appropriately. I do respect a professionally appointed accessory, whether it's a purse or briefcase, after all. Who loves you, Baby?

Tell 'em, Telly.

Judge Hall serves in the Stockton WCAB. She is a frequent contributor to workers' compensation programs and is currently a member of the Executive Committee of this Section.

Caution: Increased MCLE Audits Ahead!

THE HON. W. KEARSE MCGILL

Stockton, California

All attorneys whose licenses are in active status must satisfy the California State Bar's Minimum Continuing Legal Education (MCLE) program requirements every three years. Unless an attorney has a specific exemption from the MCLE program requirements (such as state employment), an attorney must complete twenty-five (25) hours of participatory classwork with a California State Bar approved–provider, of which up to half of those hours (12.5) can be earned through self-study within the attorney's three-year cycle. Within the total hours required, an attorney must complete four (4) hours of ethics and one (1) hour each in the detection and prevention of substance abuse or mental illness and in the elimination of bias in the legal profession.

The three-year cycle for each attorney is established by using the first letter of the attorney's last name. For example, an attorney whose last name begins with one of the letters A through G must complete the MCLE requirements no later than January 1, 2013. At the time of reporting one's completion of the requirements, an attorney is required to certify under penalty of perjury that the attorney has completed the requirements.

The California State Bar audits attorneys for MCLE program compliance. Last year it discovered that an audit of 635 attorneys (representing one percent of those who were in last year's reporting group) revealed 98 attorneys who were not in compliance. Of those who were not in compliance, the State Bar is investigating 27 attorneys for falsely reporting compliance. Recently, the State Bar announced that three of those attorneys will be referred for prosecution. Because of those findings, the State Bar announced that it was increasing its audit rates from the usual one percent to five percent of those who are in the reporting group this year and then will audit ten percent of the reporting group next year.

Dina DiLoreto, who is the State Bar's managing director of member records and information, said that attorneys should consider a few points in making sure an audit request they may receive from the State Bar goes smoothly. First, she said, is to keep all certificates of attendance and other program materials for at least one year after the February 1 reporting deadline. She also recommends keeping a separate log of courses taken in case that documentation is lost, because State Bar–approved MCLE providers are required to keep their own attendance records for four years and can provide proof of attendance if an attorney loses attendance information.

Another point DiLoreto stresses is that an attorney needs to make sure that a program is in fact approved by the California State Bar for MCLE. While some programs publicly state that approval is pending, only programs that are approved will count towards an attorney's MCLE requirements.

A third point DiLoreto mentions is that *all* active attorneys are required to report MCLE compliance, and that includes those attorneys who are exempt from taking MCLE classes, such as state employees. "In short," DiLoreto says, "everyone has to send in a compliance statement when it is due. Therefore, if an active member is randomly selected for audit, the State Bar can see if an attorney is claiming compliance through credit or exemption and can ask for the appropriate documentation in the audit notice."

If an attorney realizes that at the time reporting compliance is required, the attorney will not be in compliance, DiLoreto suggests some "do's and don'ts" to mitigate the problem. Under no circumstances should an attorney sign the compliance statement without actually satisfying the requirements. "If you are going to miss the deadline for compliance, be honest with us," says DiLoreto. The financial penalty for missing the deadline is $75, and the State Bar gives those who miss the February 1 deadline sixty (60) days' notice to get into compliance before an administrative suspension of an attorney's license can occur. That is a small price to pay in comparison to the penalty that can occur if one falsely reports compliance.

When the State Bar discovers in an audit that an attorney has not in fact satisfied the requirements for MCLE compliance, it does look at the circumstances to determine if the lack of compliance was due to an honest mistake or a deliberate deception. The State Bar recognizes that some people do make honest mistakes in complying with MCLE requirements, and it will work with those attorneys who did try to comply. However, DiLoreto states that those who deliberately mislead the State Bar will face a serious investigation and probable referral to the Trial Counsel's office for discipline, and she points to the recent three referrals from last year's audit as evidence of just how seriously the State Bar takes the issue.

DiLoreto stresses that the point the State Bar would like members to understand is that audits are to help attorneys understand the importance of MCLE in their professional development. The purpose of the MCLE program is to help attorneys represent their clients better, because attorneys who regularly receive education are better prepared to meet the needs of their clients.

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15 Percent Adjustment of Permanent Disability R.I.P.

(1/1/05–12/31/12)

JUSTIN SONNICKSEN, ESQ.

Antioch, California

The road to hell is paved with good intentions.
—St. Bernard of Clarivaux

Actually, Saint Bernard's quote was, "L'enfer est plein de bonnes volontés et désirs." It sounds much lovelier in French, doesn't it?

As we all know, when SB 899 passed in 2004, it led to a massive overhaul of the workers' compensation system in California, and many of the changes had devastating effects on injured workers. However, there was one set of provisions of the new law that appeared to encapsulate the spirit of the workers' compensation bargain: Labor Code sections 4658(d)(2) and (3). These sections created an incentive for employers with 50 or more employees to make an offer of return to regular, modified, or alternative work to employees with permanent disabilities. These employers would be permitted to reduce by 15 percent the rate of permanent disability (PD) payments made after such an offer, if timely. Likewise, if, following a permanent and stationary (P&S) determination on an injury resulting in PD, the employer did not offer an injured worker the job the worker had before the injury, the remaining PD payments were to be increased by 15 percent. This provision allowed for some additional monetary consideration to be given to those workers who were unable to return to work because of the injury. Sounds simple enough.

Of course, as the opening lines of this article suggest, however well intentioned the statute was, it has led to a great deal of litigation over the interpretation of its terms. The drafters of the statute perhaps did not fully contemplate several scenarios that might surround an injured worker's return to work. To the best of this author's knowledge, there has not been a WCAB en banc decision interpreting the provisions of Labor Code sections 4658(d)(2) and (3), although a couple of Court of Appeal decisions regarding the statute have been published.

Furthermore, several Board panel decisions have interpreted the statute, and not surprisingly, the Commissioners often reach conflicting results. At times, frankly, to accomplish an equitable result, the Board has read into the statute language that does not exist. (As we know from the Supreme Court decision in *Baker v. W.C.A.B.* (2011) 76 Cal.Comp.Cases 701, the Court "may reject a literal construction that is contrary to the legislative intent apparent in the statute or that would lead to absurd results.")

Here are some examples of potentially troublesome situations that may arise that are not easily resolved by a reading of Labor Code sections 4658(d)(2) and (3):

1. The statute says the offer of work should be sent within 60 days of an injury becoming P&S. What if the AME or QME assigns a retroactive P&S date or takes more than 60 days from the date of the examination to issue the report?

2. If the injured worker retires before the P&S date, is the employer obligated to make an offer of work?

3. If the employee is fired for cause, can the employer escape its liability for the 15 percent increase in PD benefits?

4. What if the injured worker returns to work after being on temporary disability (TD) but before the P&S date? A year later, the AME says the condition is P&S with ratable PD, and within 14 days of receipt of the AME report, the employer makes a valid offer of work. PD benefits have accrued retroactive to the date of termination of TD, but are these benefits now owed at the "standard" rate or at the reduced rate?

5. What if the AME issues a P&S report but does not outline permanent work restrictions, so the employer does not know if it can accommodate the injured worker? Does this situation extend the 60-day deadline for the employer to send the offer of work to the injured worker?

6. Does the injured worker have to miss time from work due to the industrial injury for the 15 percent adjustment of PD payments to apply?

7. If there are multiple periods off work with multiple P&S dates on a single injury, is the employer obligated to send an offer of work after every P&S determination? If the employer simply sends an offer within 60 days of the final P&S finding, is this compliance with the statute?

This is by no means an exhaustive list of the perplexing situations that can arise in interpreting Labor Code section 4658(d). However, these examples illustrate the challenges the Board is faced with when trying to implement this statute in a

way that is fair to the employer and the injured worker. Many of the questions that have arisen have not yet been definitively answered.

Perhaps because of the challenges present in interpreting Labor Code section 4658(d), when the Legislature recently overhauled workers' compensation again, through SB 863, it eliminated the 15 percent adjustment of PD payments for injuries occurring on or after January 1, 2013. The new Labor Code section 4658(e) sets forth the payment schedule for PD benefits without regard to whether the employer has made an offer of work. The unfortunate consequence of this change is the loss of the provisions in Labor Code sections 4658(d)(2) and (3), which really did provide injured workers who lost their jobs due to injury with a small financial cushion—a cushion that became even more necessary several years ago, after the elimination of vocational rehabilitation.

Nevertheless, since there will be litigation involving pre–January 1, 2013, injuries for several years to come, it may be helpful to briefly summarize some of the cases that have interpreted this sincere yet flawed statute.

Note: Unless otherwise stated, these are three-member Board panel decisions and are meant to be illustrative. They are not binding precedent on other cases.

Audiss v. City of Rohnert Park (2007) Cal Wrk Comp PD LEXIS 9

The WCAB found that the injured worker's continuation of her regular work following the injury and at the time of the P&S date was "sufficiently equivalent" to a notice of regular work and permitted defendant to reduce her entire monetary PD award by 15 percent. The WCAB did point out that the employer offered applicant her regular work but not on the correct AD Form 10003 because the form was not in existence at the time of the offer.

Reyes v. City of Los Angeles (2007) Cal Wrk Comp PD LEXIS 113

The WCAB held that the 15 percent adjustment of PD applied only to applicant's PD award payments, not to life pension payments. Applicant was also awarded a section 5814 penalty based on defendant's reducing the PD payments by 15 percent without making a valid offer of return to work.

Brown v. County of San Mateo (2008) Cal Wrk Comp PD LEXIS 425

The Board upheld the WCJ in refusing to allow a 15 percent reduction of PD benefits despite applicant's continued employment by the employer. The Board stated that the logic behind *Audiss, supra,* was no longer valid since the Administrative Director offer of work form had since been created.

Jauregui v. Mercy Southwest (2008) Cal Wrk Comp PD LEXIS 582

The Board held that the employer's duty to offer regular, modified, or alternative work is not triggered until all of applicant's disabilities are P&S. It awarded a 15 percent increase in PD benefits even though an offer of modified work was timely made since applicant was actually still working in her regular capacity at the employer at the time of the offer.

City of Los Angeles v. WCAB (Nguyen) (2008) 73 Cal. Comp.Cases 1348

In this writ-denied case, the Court of Appeal upheld the WCAB award of a 15 percent increase in PD benefits because the employer offered applicant regular work when he should have been offered modified work.

Ornelaz v. Albertsons (2008) Cal Wrk Comp PD LEXIS 724

This case represents a situation where the Board read language into the statute in order to achieve an equitable result. The Board held that an employer has 60 days from the service of the AME or QME P&S report (plus five days for mail) to make a timely offer of work and then reduce the remaining PD payments by 15 percent. Of course, the statute says nothing about the date of a report (or the service thereof) as the trigger date of the start of the 60 days; it merely indicates a time frame "within 60 days of a disability becoming permanent and stationary."

Pena v. City of Santa Rosa (2009) Cal Wrk Comp PD LEXIS 239

The Board did not allow defendant a 15 percent reduction on the entire PD award despite defendant's timely offer of return to work. Applicant returned to work prior to the P&S date, but defendant failed to advance PD in accordance with Labor Code section 4650 upon the termination of TD benefits. The accrued PD benefits should have been paid at the unadjusted rate.

Bontempo v. WCAB (2009) 74 Cal.Comp.Cases 419

In a rare published Court of Appeal decision on this issue, the Court held that applicant's failure to specifically list a 15 percent adjustment of PD as an issue in the Pre-Trial Conference Statement did not constitute a waiver of his entitlement to that increase when the box labeled "permanent disability" was checked and the evidence at trial otherwise supported a 15 percent increase in PD benefits. The Court noted that defendant was already paying applicant PD at the increased rate at the time of the MSC.

Boatman v. Town of Windsor (2009) Cal Wrk Comp PD LEXIS 615

The Board did not allow a 15 percent reduction in PD benefits where the injured worker missed two weeks of work and then returned to his pre-injury job. Furthermore, it pointed out that the offer of work was made more than 60 days after the P&S date (albeit it was made four days after defendant received the P&S report).

***Marincik v. City of Santa Rosa* (2012) Cal Wrk Comp PD LEXIS 199**

The Board granted defendant's request to reduce the entire PD award by 15 percent even though it had failed to advance PD benefits immediately upon the termination of TD benefits (which occurred several months before the eventual P&S date). The Board found that at the time of applicant's return to work, the medical evidence did not support a finding of permanent impairment, and therefore defendant was not obligated to advance PD benefits before the P&S date.

***Parker v. The Georgia Force* (2012) Cal Wrk Comp PD LEXIS 250**

The Board held that the provisions of Labor Code section 4658(d) allowing for the 15 percent increase in PD benefits apply even if the employer is no longer in business and even if it conducts its primary business outside of California.

***City of Sebastopol v. WCAB (Braga)* 77 Cal.Comp.Cases 783**

The 1st District Court of Appeal issued a published decision on August 28, 2012, in this case. In *Braga*, the injured worker remained in his regular job after the injury and suffered no lost time from work due to the injury. The employer made a timely offer of regular work to applicant and accordingly reduced the rate of the PD payments by 15 percent. The Court of Appeal held that the provisions of Labor code sections 4658(d)(2) and (3) do not apply where there is no lost time from work. In doing so, the Court reasoned that the justification behind Labor Code section 4658(d) is to create an incentive for employers to return disabled employees to work following their injuries. However, this return-to-work incentive is absent for employees who are currently working at their regular job and have lost no time from work due to the injury.

The problem with the Court's decision in *Braga* is that Labor Code sections 4658(d)(2) and (3) make no distinction, when determining whether the 15 percent adjustment of PD benefits applies, between employees who have lost time from work and those who have not. This is another example of the Court's reading language into the statute that does not exist. When statutory language is clear, courts are to adopt the literal meaning of the language unless a strict interpretation would lead to absurd results. The flawed assumption behind the Court's decision in *Braga* is that the statute was meant to provide employers whose workers suffer TD and wage loss due to work injuries with an incentive to return them to work. However, it is the employer's ability and willingness to accommodate PDs and permanent work restrictions that is the subject of Labor Code section 4658(d) and the justification behind the corresponding 15 percent increase or decrease in that benefit. Frankly, this decision will lead to inequitable results for those employers who do retain the services of their disabled employees. A plain-language interpretation of the statute would not have led to an absurd result in this instance; quite the opposite is true.

Perhaps the Court's decision in *Braga* underscores the reason the Legislature, with SB 863, decided to scrap the 15 percent adjustment of PD benefits. As one can see, the statute has led to a great deal of litigation and confusion. In some instances the statute has caused judges to "rewrite" provisions of the statute in order to effectuate what they feel is a proper result. However, it is this author's opinion that rather than an entire repeal of the adjustment provision, a more carefully drafted statute regarding the obligation to offer a return to work could have resulted in a distribution of PD benefits that would be fair to both employee and employers. If anything, this author was hopeful that with the pending legislation, there would perhaps be an increase in the percentage number of the PD benefit adjustment in order to give the law more "teeth."

How many times, as attorneys, have we seen employers use a workers' compensation P&S report to get rid of an employee who has filed a claim? How many times have we seen long-term employees working on modified duty at large employers following an injury get terminated immediately on receipt of the P&S report with restrictions from the AME or QME? Perhaps if the PD adjustment percentage were closer to 25 percent, or even 50 percent, large employers would search a tiny bit harder for that elusive modified position for the injured worker that often escapes them now.

Nevertheless, despite the noble motives behind a law designed to reward employers who make the effort to retain the services of their disabled employees while also giving some monetary solace to those unfortunate employees who cannot continue working at the employer because of the injury, it is time to bid farewell to the 15 percent adjustment of PD payments for injuries occurring after January 1, 2013. May Labor Code sections 4658(d)(2) and (3) rest in peace; au revoir.

Justin Sonnicksen is an applicant attorney with Pegnim & Ivancich, LLP, which represents clients in personal injury, social security disability, and workers' compensation cases. Mr. Sonnicksen is a current member of the Executive Committee of the Workers' Compensation Section of the State Bar of California.

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180 Howard Street
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VOL. 25, No. 4
2013

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