

APPEALS
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NO. 41601-8-II

COURT OF APPEALS, DIVISION II

SINAIPUA LEULUAIALII,
Appellant,

v.

STATE OF WASHINGTON, DEPARTMENT OF LABOR AND INDUSTRIES
ET AL,
Respondents.

APPEAL FROM THE SUPERIOR COURT FOR PIERCE COUNTY
Honorable John A. McCarthy, Judge
Cause No. 09-2-15149-6

BRIEF OF APPELLANT SINAIPUA LEULUAIALII

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I. INTRODUCTION¹

Appellant Sinaipua L. Leuluai filed an industrial insurance claim for an injury to her right knee sustained on May 31, 2006 which was assigned self-insured claim number W-373492. Ms. Leuluai's attending physician for purposes of the claim was Dr. Patrick Vaughn, whose address was listed as being at 2420 S. Union Ave., Ste. 300, Tacoma, WA 98405. This fact is substantiated by the self-insured employer's form "SIF-5,"² dated May 5, 2008, signed by the employer's authorized representative, Tiffany Brockman, which indicates the claimant's attending physician to be Dr. Patrick Vaughn. The employer's SIF-5 form was sent to the Department of Labor & Industries ["Department"], Self-Insurance Section, requesting closure of the claim with permanent impairment and listing claimant's attending physician as Dr. Patrick Vaughn.

¹ Note – the Certified Appeal Board Record for this case, which is the record of all documents and proceedings before the Board of Industrial Insurance Appeals, is 284 pages long. Many of these records are duplicates. For ease of reference to the relative issues at hand, Appellant is attaching the Proposed Decision and Order of the Board and the Decision and Order of the Board.

² The SIF-5, "Report of Occupational Injury or Disease," is a form a self-insured employer uses to report initial time loss payments or to request interlocutory, wage, overpayment or closure orders.

In response, on May 16, 2008, the Department issued an order closing Ms. Leuluaialii's claim with a permanent partial disability impairment equal to 19 percent of the amputation value of the **right arm** at or above the deltoid insertion or by disarticulation at the shoulder. This amounted to a monetary award of \$18,076.23. The closing order was not protested or appealed within the statutory sixty (60) day deadline. Ms. Leuluaialii protested this order on October 10, 2008, because the Department order assigned an impairment value to the wrong body part. In response to this protest, the Department issued a further order on October 14, 2008, which corrected the order of May 16, 2008 and awarded Ms. Leuluaialii an impairment equal to 19 percent of the amputation value of the **right leg** above the knee joint with short thigh stump. The dollar amount remained the same,³ the claim remained closed, and no further benefits were awarded.

At the Board level following appeal of the October 14, 2008 order, the Board determined that the Department did not have subject matter jurisdiction to issue the October 14, 2008 because the May 16, 2008 order became final and binding. Appellant

³ The dollar amounts for the percentage value for the upper and lower extremities are equal.

argues that RCW 51.32.240 authorizes the Department to correct any orders that contain clerical errors that are not the result of deliberate misrepresentation or fraud, and to do so within one year of the issuance of those orders. Appellant also argues that, pursuant to the Washington Supreme Court's holding in *Shafer v. Department of Labor and Industries*, a closing order that was not communicated to the attending physician in a claim is not a final and binding order. Since Dr. Vaughn was the attending physician on the claim (and the Respondent's own documentation shows him as such), and the closing order of May 16, 2008 reflects that it was sent to a different physician, said order was never in fact communicated to Dr. Vaughn and the claim could not be closed pursuant to recent case law. Thus, if the claim was not closed, and the closing order was not final and binding, the Board did not have subject matter jurisdiction to hear the case in the first place.

II. ASSIGNMENTS OF ERROR

Appellant assigns error to the trial court's finding that the October 6, 2009 decision of the Board of Industrial Insurance Appeals was correct and affirmed when it determined that the Department lacked subject matter jurisdiction to issue the October

14, 2008 order, and that Ms. Leuluai was unable to show that the attending physician did not get a copy of the closing order.

a. Issue:

Did the Department of Labor and Industries have subject matter jurisdiction to issue the October 14, 2008 order correcting the May 16, 2008 order pursuant to RCW 51.32.240?

Answer: Yes, it did.

b. Issue:

Was the May 16, 2008 closing order communicated to the attending physician in the claim, as mandated by the Washington State Supreme Court's holding in *Shafer v. Department of Labor and Industries*?

Answer: No, it was not.

III. STATEMENT OF THE CASE

a. Facts.

On November 26, 2008, the Appellant appealed the October 14, 2008 order to the Board of Industrial Insurance Appeals ["Board"]. Once the case was presented to the Board, the parties entered into a stipulated agreement that stated, among other things, that: 1) the May 16, 2008 order was properly communicated

to all **parties**; 2) Ms. Leuluaialii requested that the Department correct the May 16, 2008 order pursuant to RCW 51.32.240(2)(a); 3) the Department issued the October 14, 2008 order within one year of the May 16, 2008 order in response to Ms. Leuluaialii's request; and, 4) Ms. Leuluaialii timely appealed the October 14, 2008 order. This stipulation was signed by the parties on May 11, 2009.

The parties submitted the stipulation and exhibits to the Board Judge assigned to the case, who issued a Proposed Decision and Order on June 23, 2009. In his decision, the Judge found the Department did not have subject matter jurisdiction to issue the October 14, 2008 order, and that RCW 51.32.240 did not give it authority to issue the order changing the extremity involved in the permanent partial disability award issued by the Department. Therefore, per the Proposed Decision and Order, the October 14, 2008 was incorrect and reversed, and the matter was remanded to the Department.

Ms. Leuluaialii filed a Petition for Review with the Board on August 3, 2009. On August 17, 2009, Appellant filed an Amended Petition for Review, and added a Motion to Dismiss, in which she raised for the first time the argument that the Board did not have

subject matter jurisdiction over the issues in the claim because, pursuant to the just-decided Washington Supreme Court decision in *Shafer v. Department of Labor and Industries*⁴, the closing order of May 16, 2008 was never communicated to the attending physician in the claim and thus, the closing order could not be considered final. Thereafter, the Board issued a final Decision and Order on October 6, 2009, affirming the Proposed Decision and Order. The Board denied Ms. Leuluaialii's Motion to Dismiss.

Appellant then filed suit in Pierce County Superior Court. Respondent filed a Motion for Summary Judgment on May 26, 2010, claiming that since no protest or appeal was filed to the May 16, 2008 closing order, and the parties had entered into a Stipulation of Facts in May of 2009, there was no genuine issue of material fact. Ms. Leuluaialii filed a response, and the Court subsequently denied the Respondent's summary judgment motion. The parties then filed trial briefs and replies for a bench trial, and oral argument was heard on October 21, 2010. The Court issued its decision on November 17, 2010, affirming the Board's decision

⁴ *Shafer v. Department of Labor and Industries*, 166 Wn. 2nd 710, 213 P. 3rd 591 (2009), was decided on August 13, 2009.

and order, and the final Judgment and Order was signed on December 3, 2010.

IV. LAW

RCW 51.32.240 contains seven sections altogether, and since many of them impact the present case, it is necessary to quote it in full:

51.32.240. Erroneous payments--Payments induced by willful misrepresentation--Adjustment for self-insurer's failure to pay benefits--Recoupment of overpayments by self-insurer--Penalty--Appeal--Enforcement of orders.

(1)(a) Whenever any payment of benefits under this title is made because of clerical error, mistake of identity, innocent misrepresentation by or on behalf of the recipient thereof mistakenly acted upon, or any other circumstance of a similar nature, all not induced by willful misrepresentation, the recipient thereof shall repay it and recoupment may be made from any future payments due to the recipient on any claim with the state fund or self-insurer, as the case may be. The department or self-insurer, as the case may be, must make claim for such repayment or recoupment within one year of the making of any such payment or it will be deemed any claim therefor has been waived.

(b) Except as provided in subsections (3), (4), and (5) of this section, the department may only assess an overpayment of benefits because of adjudicator error when the order upon which the overpayment is based is not yet final as provided in RCW 51.52.050 and 51.52.060. "Adjudicator error" includes the failure to

consider information in the claim file, failure to secure adequate information, or an error in judgment.

(c) The director, pursuant to rules adopted in accordance with the procedures provided in the administrative procedure act, chapter 34.05 RCW, may exercise his or her discretion to waive, in whole or in part, the amount of any such timely claim where the recovery would be against equity and good conscience.

(2) Whenever the department or self-insurer fails to pay benefits because of clerical error, mistake of identity, or innocent misrepresentation, all not induced by recipient willful misrepresentation, the recipient may request an adjustment of benefits to be paid from the state fund or by the self-insurer, as the case may be, subject to the following:

(a) The recipient must request an adjustment in benefits within one year from the date of the incorrect payment or it will be deemed any claim therefore has been waived.

(b) The recipient may not seek an adjustment of benefits because of adjudicator error. Adjustments due to adjudicator error are addressed by the filing of a written request for reconsideration with the department of labor and industries or an appeal with the board of industrial insurance appeals within sixty days from the date the order is communicated as provided in RCW 51.52.050. "Adjudicator error" includes the failure to consider information in the claim file, failure to secure adequate information, or an error in judgment.

(3) Whenever the department issues an order rejecting a claim for benefits paid pursuant to RCW 51.32.190 or 51.32.210, after payment for temporary disability benefits has been paid by a self-insurer pursuant to RCW 51.32.190(3) or by the department

pursuant to RCW 51.32.210, the recipient thereof shall repay such benefits and recoupment may be made from any future payments due to the recipient on any claim with the state fund or self-insurer, as the case may be. The director, under rules adopted in accordance with the procedures provided in the administrative procedure act, chapter 34.05 RCW, may exercise discretion to waive, in whole or in part, the amount of any such payments where the recovery would be against equity and good conscience.

(4) Whenever any payment of benefits under this title has been made pursuant to an adjudication by the department or by order of the board or any court and timely appeal therefrom has been made where the final decision is that any such payment was made pursuant to an erroneous adjudication, the recipient thereof shall repay it and recoupment may be made from any future payments due to the recipient on any claim whether state fund or self-insured.

(a) The director, pursuant to rules adopted in accordance with the procedures provided in the administrative procedure act, chapter 34.05 RCW, may exercise discretion to waive, in whole or in part, the amount of any such payments where the recovery would be against equity and good conscience. However, if the director waives in whole or in part any such payments due a self-insurer, the self-insurer shall be reimbursed the amount waived from the self-insured employer overpayment reimbursement fund.

(b) The department shall collect information regarding self-insured claim overpayments resulting from final decisions of the board and the courts, and recoup such overpayments on behalf of the self-insurer from any open, new, or reopened state fund or self-insured claims. The department shall forward the amounts collected to the self-insurer to whom the payment is owed. The department may provide information as needed to any self-insurers from whom payments

may be collected on behalf of the department or another self-insurer. Notwithstanding RCW 51.32.040, any self-insurer requested by the department to forward payments to the department pursuant to this subsection shall pay the department directly. The department shall credit the amounts recovered to the appropriate fund, or forward amounts collected to the appropriate self-insurer, as the case may be.

(c) If a self-insurer is not fully reimbursed within twenty-four months of the first attempt at recovery through the collection process pursuant to this subsection and by means of processes pursuant to subsection (6) of this section, the self-insurer shall be reimbursed for the remainder of the amount due from the self-insured employer overpayment reimbursement fund.

(d) For purposes of this subsection, "recipient" does not include health service providers whose treatment or services were authorized by the department or self-insurer.

(e) The department or self-insurer shall first attempt recovery of overpayments for health services from any entity that provided health insurance to the worker to the extent that the health insurance entity would have provided health insurance benefits but for workers' compensation coverage.

(5)(a) Whenever any payment of benefits under this title has been induced by willful misrepresentation the recipient thereof shall repay any such payment together with a penalty of fifty percent of the total of any such payments and the amount of such total sum may be recouped from any future payments due to the recipient on any claim with the state fund or self-insurer against whom the willful misrepresentation was committed, as the case may be, and the amount of such penalty shall be placed in the supplemental

pension fund. Such repayment or recoupment must be demanded or ordered within three years of the discovery of the willful misrepresentation.

(b) For purposes of this subsection (5), it is willful misrepresentation for a person to obtain payments or other benefits under this title in an amount greater than that to which the person otherwise would be entitled. Willful misrepresentation includes:

(i) Willful false statement; or

(ii) Willful misrepresentation, omission, or concealment of any material fact

(c) For purposes of this subsection (5), "willful" means a conscious or deliberate false statement, misrepresentation, omission, or concealment of a material fact with the specific intent of obtaining, continuing, or increasing benefits under this title.

(d) For purposes of this subsection (5), failure to disclose a work-type activity must be willful in order for a misrepresentation to have occurred.

(e) For purposes of this subsection (5), a material fact is one which would result in additional, increased, or continued benefits, including but not limited to facts about physical restrictions, or work-type activities which either result in wages or income or would be reasonably expected to do so. Wages or income include the receipt of any goods or services. For a work-type activity to be reasonably expected to result in wages or income, a pattern of repeated activity must exist.

For those activities that would reasonably be expected to result in wages or produce income, but for which actual wage or income information cannot be reasonably determined, the department shall impute wages pursuant to RCW 51.08.178(4).

(6) The worker, beneficiary, or other person affected thereby shall have the right to contest an order assessing an overpayment pursuant to this section in the same manner and to the same extent as provided under RCW 51.52.050 and 51.52.060. In the event such an order becomes final under chapter 51.52 RCW and notwithstanding the provisions of subsections (1) through (5) of this section, the director, director's designee, or self-insurer may file with the clerk in any county within the state a warrant in the amount of the sum representing the unpaid overpayment and/or penalty plus interest accruing from the date the order became final. The clerk of the county in which the warrant is filed shall immediately designate a superior court cause number for such warrant and the clerk shall cause to be entered in the judgment docket under the superior court cause number assigned to the warrant, the name of the worker, beneficiary, or other person mentioned in the warrant, the amount of the unpaid overpayment and/or penalty plus interest accrued, and the date the warrant was filed. The amount of the warrant as docketed shall become a lien upon the title to and interest in all real and personal property of the worker, beneficiary, or other person against whom the warrant is issued, the same as a judgment in a civil case docketed in the office of such clerk. The sheriff shall then proceed in the same manner and with like effect as prescribed by law with respect to execution or other process issued against rights or property upon judgment in the superior court. Such warrant so docketed shall be sufficient to support the issuance of writs of garnishment in favor of the department or self-insurer in the manner provided by law in the case of judgment, wholly or partially unsatisfied. The clerk of the court shall be entitled to a filing fee under RCW 36.18.012(10), which shall be added to the amount of the warrant. A copy of such warrant shall be mailed to the worker, beneficiary, or other person within three days of filing with the clerk.

The director, director's designee, or self-insurer may issue to any person, firm, corporation, municipal corporation, political subdivision of the state, public corporation, or agency of the state, a notice to withhold and deliver property of any kind if there is reason to believe that there is in the possession of such person, firm, corporation, municipal corporation, political subdivision of the state, public corporation, or agency of the state, property that is due, owing, or belonging to any worker, beneficiary, or other person upon whom a warrant has been served for payments due the department or self-insurer. The notice and order to withhold and deliver shall be served by certified mail accompanied by an affidavit of service by mailing or served by the sheriff of the county, or by the sheriff's deputy, or by any authorized representative of the director, director's designee, or self-insurer. Any person, firm, corporation, municipal corporation, political subdivision of the state, public corporation, or agency of the state upon whom service has been made shall answer the notice within twenty days exclusive of the day of service, under oath and in writing, and shall make true answers to the matters inquired or in the notice and order to withhold and deliver. In the event there is in the possession of the party named and served with such notice and order, any property that may be subject to the claim of the department or self-insurer, such property shall be delivered forthwith to the director, the director's authorized representative, or self-insurer upon demand. If the party served and named in the notice and order fails to answer the notice and order within the time prescribed in this section, the court may, after the time to answer such order has expired, render judgment by default against the party named in the notice for the full amount, plus costs, claimed by the director, director's designee, or self-insurer in the notice. In the event that a notice to withhold and deliver is served upon an employer and the property found to be subject thereto is wages, the employer may assert in the answer all exemptions provided for

by chapter 6.27 RCW to which the wage earner may be entitled.

This subsection shall only apply to orders assessing an overpayment which are issued on or after July 28, 1991: PROVIDED, That this subsection shall apply retroactively to all orders assessing an overpayment resulting from fraud, civil or criminal.

(7) Orders assessing an overpayment which are issued on or after July 28, 1991, shall include a conspicuous notice of the collection methods available to the department or self-insurer.

In *Shafer v. Department of Labor and Industries*, 166 Wn. 2d 710, 213 P. 3d 591 (2009), the Washington Supreme Court held that a workers' compensation claim is not properly closed nor is a closing order final unless the worker's attending physician receives a copy of the closing order. The Court further held that a worker's claim is not final until 60 days after the attending physician receives a copy of the order.

V. ARGUMENT

The Industrial Insurance Act [hereinafter "act"] was written to provide sure and certain relief to injured workers. *Dennis v. Dept. of Labor & Industries*, 109 Wn.2d 467, 470, 475 P.2d 1295 (1987). All doubts are to be resolved in favor of the injured worker. *Dennis*, 109 Wn.2d at 470. In *Cockle v. Dept. of Labor and Industries*, 142

Wn.2d 801, 16 P.3d 583 (2001), the Court observed the “overarching objective” of Title 51 RCW is to reduce to a minimum “the *suffering* and economic loss arising from injuries and/or death occurring in the course of employment.” *Cockle*, 142 Wn.2d at 822, 16 P.3d 583 (quoting RCW 51.12.010) (emphasis added). “Also, on a practical level, this Court has recognized that the workers’ compensation system should continue “serv[ing] the goal of swift and certain relief for injured workers.” *Cockle*, 142 Wn.2d at 822, 16 P.3d 583 (quoting *Weyerhaeuser Co. v. Tri*, 117 Wn.2d 128, 138, 814 P.2d 629 (1991)).

A. RCW 51.32.240 grants the Department authority to correct clerical errors in an order within one year of an order’s issuance.

Ms. Leuluaialii contends that RCW 51.32.240 does in fact give the Department jurisdiction to issue a subsequent determinative order beyond the 60 day time period if certain requirements are met. It is clear from a reading of the orders issued the “error” that occurred was a “clerical error” which would fall under the ambit of RCW 51.32.240(2). It is clear that RCW 51.32.240 gives the Department of Labor & Industries broad jurisdictional powers. Each section of the statute should be applied

in a consistent manner taking into consideration that there are seven (7) subsections that should be addressed with equal importance and consistency, thus, leading to uniformity and certitude.

The present case presents the question of whether a uniform policy and application of the statute should apply or whether a “pick and choose” approach should be taken. The dollar amounts for permanent partial disability awards are set by the State legislature. In this particular case the dollar amount of the award for amputation value of the upper extremities and the lower extremities are the same under Washington Industrial Insurance Law. If a claimant is awarded a 19% permanent partial disability award of the right upper extremity at a certain level, or “amputation value” as it’s described using the Guides to the Evaluation to Permanent Impairment published by the American Medical Association, it would be the same dollar amount as a 19% disability award to the right lower extremity at the same level. This then becomes “a failure to pay” the proper benefit, because the Department in effect pays an award for a body part that was not injured and not allowed by the claim, and in turn withholds payment for an injured body part that was administratively accepted under the claim.

It is clear under section (1)(a) that “Whenever **any** payment of benefits under this title is made because of clerical error ... or any other circumstance of a similar nature,” that the statute specifically addresses “any” payments that are made under the title. Section “(1)(a)” addresses the rights of the Department or self-insurer to make a claim for recoupment of payments within one year (or else such claims would be waived). This also affords protection for a claimant if the Department or self-insurer does not exercise their rights within one year, preventing the Department or self-insured employer from coming back to the injured worker after one year and trying to recoup the payment.

Under section “(2)” it states, “Whenever the Department or self-insurer fails to pay benefits because of a clerical error, ...,” “The recipient may request an adjustment of benefits to be paid from the State fund or by the self-insurer, as the case may be, subject to section “(2)(a)” that the recipient must request an adjustment of benefits within one year from the date of the incorrect payment or it will be deemed forever waived.” This section protects the Department, employers, and self-insurers from potentially stale claims made years later by claimants. It should be noted that this provision of the statute specifically states “...the failure to pay

benefits.” When applying the plain language of a statute, the words, “failure to pay benefits,” by implication means failure to pay **proper** benefits. Even though a dollar amount may be equal for a different part of the body, failure to pay the appropriate benefits for the appropriate injured body part is what the statute covers.

Section 51.32.240 was enacted to address the above-mentioned potential problems. Certainly, if the Department enters an erroneous order due to a clerical error, the matter should be properly corrected to reflect the facts in the case. In this particular situation, the Department of Labor & Industries was within its jurisdictional powers when it undertook a request by Ms. Leuluaialii to correct the erroneous language in the May 16, 2008 order when that request was made within one year of the issuance of the order. Certainly, when a claimant such as Ms. Leuluaialii makes a request for adjustment it is theoretically possible that yet another incorrect order could be mistakenly entered. If that is the case, the claimant would still have appeal rights under RCW 51.52.050 and under RCW 51.32.240. The purpose of the two sections when read in conjunction is to ascertain legal certainty in conformance with the facts of the case.

Under RCW 51.32.240(7), the statute specifically addresses subsequent orders that are entered that may assess an overpayment and mandates that a “conspicuous notice of the collections methods be made available to the Department or self-insurer.” This section and the other sections all imply that the Department has the ability to take further action which means that **the Department has authority to enter determinative appealable definitive orders under RCW 51.32.240**. Furthermore, under subsection “6” it states that, “The worker, beneficiary, or other person affected thereby shall have the right to contest an order assessing an overpayment pursuant to this section in the same manner and to the same extent as provided under RCW 51.52.050 and 51.52.060.” Once the Department exercised its power under RCW 51.32.240 following a timely request within one year by Ms. Leuluaialii to correct the erroneous order and issue it in accordance with the facts of the case, the Department was within its authority to enter the subsequent order, which it did on October 14, 2008. The Department was within its jurisdiction in re-entering wage order information, which did not change from the May 16, 2008 order, closing the claim once again, and directing payment of a permanent partial disability award of 19% of the amputation value of the right

leg above the knee in the amount of \$18,076.23. Once this order was entered Ms. Leuluaialii was well within her statutory rights to file a protest and/or appeal of the order within the 60 days as allowed by law.

The Superior Court held that the Department did not have authority to issue the October 2008 order correcting the May 2008 order that contained the clerical error, and therefore the May 2008 order was final and binding because RCW 51.32.240 did not apply and no party appealed or protested the May 2008 order within the 60 day statutory deadline. Once an order is final and binding, it cannot be changed, per Respondent's argument made before the Board and the Superior Court (which in turn was adopted by the Board and the Court). Because Ms. Leuluaialii did not contest the May 16, 2008 order within 60 days, and RCW 51.32.240 does not give the Department jurisdiction to act in this case, Ms. Leuluaialii is forever barred from contesting this order. The order then becomes *res judicata*. Ms. Leuluaialii contends that if such were the case, she could file to reopen⁵ her claim for her lower leg immediately, asserting that, from a purely legal standpoint, she had no

⁵ An injured worker has seven years from the date of the first, final claim closure to reopen a claim if he or she can show objective medical signs of worsening to the affected area(s) or condition(s) administratively accepted by the Department.

permanent partial disability, or “impairment,” for that extremity, but could immediately meet the requirements for reopening because she now had an immediate “worsening” of 19% as shown by objective medical evidence.

This would lead to a legal absurdity, wherein the employer and the Department would now be responsible for paying an additional amount for the actual body part affected by the industrial injury despite having paid the same amount for a “phantom” injury to a limb that never occurred since, the Court’s and the Board’s reasoning, that order granting the permanent partial disability was final and binding and could not now be changed. At oral argument before the Court, Respondent asserted that if Ms. Leuluai did in fact attempt this, the Department could change the order that contained the error at the time of the reopening by pointing out that the Plaintiff really should have received the impairment award for the leg, not the arm, and the Department could now recoup the money from future benefits. However, Plaintiff asks this Court how the Department could in fact “correct” the May 2008 order now, two years later, if Plaintiff tried to reopen the claim, if that order is *res judicata*? Under what legal authority would the Department act? And, last, would it not be better to correct the problem within the

one year statutory deadline contemplated by RCW 51.32.240, as the Department attempted to do in October of 2008, rather than allow the problem to arise at a later date outside of any statutory authority?

The Court's argument does not make logical sense: either the Department's May 2008 order was in error and fell within the purview of RCW 51.32.240 and thus, the Department had the authority to correct it within one year, as it did so in October of 2008; or it was final and binding because it was not appealed within 60 days, RCW 51.32.240 does not apply, and the Department could not correct it in October of 2008, and cannot do so now or any time in the future. It cannot be both. Ms. Leuluaialii contends that RCW 51.32.240 contemplates clerical errors of this nature, and was established to prevent legal absurdities such as this. The legislature granted authority to the Department to correct orders that contained clerical errors within one year, the Department did so in this case, and thus the Department did have subject matter jurisdiction under the statute and the law to issue the October 14, 2008 order.

Oddly, in the Proposed Decision and Order, the hearings Judge noted that the Board case of *In re Geraldine Gallant*, BIIA

Dckt. Nos., 03 16903 & 03 19604(1994) presents facts analogous to the present case, with the exception being that the claimant in that case waited five (5) years before she filed a protest to have the correction made for the order that paid an award for the wrong extremity. The Board held she was barred from appealing even under RCW 51.32.240 if the order was not appealed, and that an order is not void if entered with personal and subject matter jurisdiction, citing *Marley v. Department of Labor & Indus.*, 125 Wn.2d 533, 542-42, 899 P.2d 189 (1994). Of course, the main difference between the two cases is that Ms. Leuluai did not wait five years to request a correction, but did so within the one year statutory deadline contemplated by RCW 51.32.240.

The Board also cited *Callihan v. Department of Labor and Industries*, 10 Wn. App. 153, 516 P.2d 1073 (1973), which was another case involving an award to the wrong extremity. The claimant accepted the award, did not appeal, and filed to reopen six months later. Her application was denied, and she appealed, contending the Department did not adjudicate her claim for the arm that was actually injured, and thus, the Board did not have jurisdiction to hear the appeal. The hearing judge agreed and issued an order reversing and remanding the Department's closing

order, but the full Board reversed that order and directed that the case be heard, so the claimant appealed to Superior Court, which dismissed her appeal. Claiming she could not appeal an order that was not a final order, whereupon she appealed to the Court of Appeals.

The Court of Appeals pondered the question of whether the Board could hear the case regarding the improper award and correct the error without a remand to the Department. The Court held that:

Inadvertent clerical errors creep into both administrative and judicial proceedings. The manner of handling clerical errors in judicial proceedings is clear. An appellate court may itself correct a clerical error in a judgment appealed from without remanding the judgment to the trial court for that purpose. A court has inherent power to correct a clerical error in order to make the true action of the court conform to the record... In judicial proceedings, rules exist to insure that substance shall not give way to form... Thus, a clerical error can be corrected without reformation. Delay is no defense to the correction of a clerical error, at least in the absence of a showing of prejudice. Such a showing cannot be made when the person claimed to be prejudiced is charged with knowledge of the error...

The exercise of such power may require that the board first determine whether a description contained in the order with reference to the injury for which an award is made is an inadvertent misdescription correctable by it. Were the rule otherwise, the board would be required to treat a

clerical error as if it were no error at all. This would give an injured plaintiff an opportunity for repetitive determination on the merits of his claim instead of only one to which all injured workmen are entitled. Even a liberal view of the industrial insurance act does not require a repetitive departmental determination. The conclusion reached would seem especially required when the injured plaintiff knows, or is charged with knowledge, that the injury is inadvertently misdescribed.

Callihan v. Department of Labor and Industries, 10 Wn. App.

153, 156-7, 516 P.2d 1073 (1973).

Callihan, while similar, is not analogous to the present case because the Board did not issue any orders to the Department to take action to correct the part of the order that was in error, and indeed, reversed the action the Department undertook on its own, in response to Appellant's request. This leads to a confusing result where in one case, *Callihan*, the Board orders to hear evidence in the case to resolve the issue, followed by the Court of Appeals framing the issue to see if the Board could correct the error without remand to the Department at all, and the present case, where the Board essentially scolds the Department for taking action and signals to it that it cannot, in the future, take any action at all in this type of situation. Again, it cannot be both, and Ms. Leuluaialii requests that the Court find that RCW 51.32.240 authorizes the Department to correct the clerical error it made.

- B. Alternatively, pursuant to the Court's holding in the *Shafer* case, because the May 16, 2008 closing order was never communicated to the attending physician, the Board did not have subject matter jurisdiction to decide any issues in Appellant's claim.**

In *Shafer v. Department of Labor and Industries*, 166 Wn.2d 710, 213 P.3d 591 (2009) the injured worker's claim was initially closed with no award for permanent impairment. A copy of the closing award was mailed to the injured worker and the injured worker's attending physician. The injured worker appealed, and in response, the Department paid her a permanent partial disability award, revising their previous order, and again closing the claim. This time, the Department mailed the order to the claimant, but did not mail the order to her attending physician. The claimant did not appeal or protest the revised closing order. Three years later, the injured worker returned to her attending physician to reopen her claim. This was the first the doctor became aware of the closing order.

The doctor filed a reopening application, which was denied by the Department. Ms. Shafer appealed, asserting that her claim had never closed because the closing order was never

communicated to her attending physician. The case eventually ended up before the Washington Supreme Court, which affirmed a Court of Appeals decision decided in the injured worker's favor.

The Supreme Court noted that the Industrial Insurance Act aims to provide a speedy remedy and enable injured workers to become gainfully employed and also noted that the Act is to be "liberally construed for the purpose of reducing to a minimum the suffering and economic loss arising from injuries and/or death occurring in the course of employment," pursuant to the provisions of RCW 51.12.010. The Court held that the Department administers the Industrial Insurance Act and "is responsible for supervising medical treatment of workers injured in the course of employment," citing RCW 51.04.020(4), 030(1). The Court found that when the Department determines that a worker's condition is stable, a closing order is issued "based on factors which include medical recommendation, advice, or examination," citing RCW 51.32.160(1)(b).

Finally, the basis of the Court's decision with respect to the **finality and the jurisdiction regarding Department closure orders** is affected by RCW 51.52.050(2)(a). The Court noted that workers and other persons aggrieved, including attending

physicians, (emphasis added), may ask the Department to reconsider or appeal directly to the Board. The Court held that “an attending physician is an aggrieved party” and noted further that, “the appeal procedure is further explained by another provision that is central to the decision and issue in the case under RCW 51.52.060(1)(a).” The Court noted that this provision provides as follows:

“A worker, beneficiary, employer, health services provider, or other person aggrieved by an order, decision, or award ... [must] file with the Board ... within 60 days from the day on which a copy of the order, decision, or award was communicated to such person, a Notice of Appeal to the Board.”

After citing these provisions, the Court concluded that a worker’s claim is not closed until the attending physician has received a copy of the closure order. Because Ms. Shafer’s attending physician never received a copy of the final closing order, her claim was never properly closed.

In the present case, despite the fact that the Respondent’s SIF-5 correctly listed Dr. Vaughn as Ms. Leuluaialii’s attending physician, with his address at 2420 S. Union Ave. Ste. 300, Tacoma, WA 98405, the Department’s May 16, 2008 closing order

lists the attending physician as “St Clare Hospital, Dept 450 PO Box 34935, Seattle, WA 98124-1935. The Department’s not only sent the order to the wrong doctor, but to the wrong address in the wrong city.

At the Superior Court and Board level, Respondent made much of the signed Stipulation of Facts between the parties, which states clearly that the May 16, 2008 order was “properly communicated to all parties (emphasis added) and no party filed a protest or appeal within sixty (60) days.” Ms. Leuluaialii does not dispute this, but makes a distinction between a “party” to a suit and a “person aggrieved” by an order, as RCW 51.52.060(1)(a) seems to do as well. CR 19 makes a distinction between a “person” and a “party” as well, when it discusses persons that may become parties if joinder is appropriate. The Courts and the statutes recognize that medical providers have a stake in worker’s compensation claims, thus necessitating that orders be communicated to them directly, but that does not necessarily mean that they are parties to a claim in the same sense that a worker, the Department, or a self-insured employer is.

RCW 51.52.050 states:

(1) Whenever the department has made any order, decision, or award, it shall promptly serve the worker, beneficiary, employer, or **other person** affected thereby, with a copy thereof by mail, which shall be addressed to such person at his or her last known address as shown by the records of the department. The copy, in case the same is a final order, decision, or award, shall bear on the same side of the same page on which is found the amount of the award, a statement, set in black faced type of at least ten point body or size, that such final order, decision, or award shall become final within sixty days from the date the order is communicated to the parties unless a written request for reconsideration is filed with the department of labor and industries, Olympia, or an appeal is filed with the board of industrial insurance appeals, Olympia. However, a department order or decision making demand, whether with or without penalty, for repayment of sums paid to a provider of medical, dental, vocational, or other health services rendered to an industrially injured worker, shall state that such order or decision shall become final within twenty days from the date the order or decision is communicated to the parties unless a written request for reconsideration is filed with the department of labor and industries, Olympia, or an appeal is filed with the board of industrial insurance appeals, Olympia.

(2)(a) Whenever the department has taken any action or made any decision relating to any phase of the administration of this title the worker, beneficiary, employer, or **other person aggrieved thereby may request reconsideration of the department, or may appeal to the board.** In an appeal before the board, the appellant shall have the burden of

proceeding with the evidence to establish a prima facie case for the relief sought in such appeal.

“Person aggrieved by” contemplates health care providers, and therefore makes a distinction between “parties,” such as the injured worker and the employer, who are routinely and intimately involved in the hearing and litigation process, and health care providers as persons, who are usually only involved in litigation as expert witnesses. Ms. Leuluaialii contends that the stipulation of facts was not intended to include attending physicians as providers, and indeed, was not written as such.

The Board and Respondent also previously noted that Ms. Leuluaialii did not bring the issue of lack of communication before the Board at the initial hearing level, and the Respondent draws on *Rogers Walla Walla v. Ballard*, 16 Wn. App. 81, 533 P.2d 1372 (1976) for the argument that she could not raise this issue later at the Petition for Review stage before the Board. This case is not analogous to *Rogers Walla Walla v. Ballard* for three reasons: one, the Ballard party in *Rogers Walla Walla* could have presented testimony regarding the stock valuation at trial, but chose not to do so, and then filed their motion to reopen the case to present this

testimony at a later time: Ms. Leuluai is not asking to reopen a case and present additional testimony here; two, no new controlling authority issued by any court came out during the disposition of *Rogers Walla Walla* that would have had a dramatic impact on the outcome, as it has in this case; three, the additional evidence Appellant submitted, along with her motions and petitions before the Board, fell within her procedural rights under the Act, and are part of the Certified Appeal Board Record that is now on file – in *Rogers Walla Walla*, the Ballard party was trying to enter additional evidence after the fact, a clear fact that distinguishes the present case before the Court.

In addition, WAC 263-12-135, which is part of the chapter that governs procedures at the Board, states that the “record” includes, among other things, “other written applications, motions, stipulations or requests duly filed by any party.” Ms. Leuluai filed her motion for reconsideration in accordance with CR 59(a)(4), which states that “[n]ewly discovered evidence, material for the party making the application, which he could not with reasonable diligence have discovered and produced at the trial” is a basis for granting a motion for a new trial and vacating a verdict on all the issues.

The Decision and Order of the Board asserts that the decision of *Shafer v. Department of Labor & Industries* “should have been brought to the attention of the Industrial Appeals Judge” for the reason that the Court of Appeals had decided the case under *Shafer v. Labor & Industries*, 140 Wn. App. 1 (June 2007). However, this was a Court of Appeals decision and it was not a final decision and was on appeal at the time of this litigation. The Court of Appeals decided *Shafer* on June 11, 2007. A reconsideration of the decision was granted in part and the opinion was modified on September 4, 2007 and another reconsideration was denied on December 18, 2007. However, the Supreme Court granted review of the Court of Appeals’ decision at 163 Wn. 2d. 1052 on July 9, 2008. THEREFORE, THE COURT OF APPEALS’S DECISION IN *SHAFER* WAS NOT FINAL LAW AND COULD NOT BE RELIED UPON WHILE A PETITION WAS PENDING BEFORE THE SUPREME COURT OF OUR STATE. (See likewise, *Tobin v. Labor & Industries*, 169 Wn.2d 396, 239 P.3d 544 (2010), which was decided favorably for the injured worker at the Court of Appeals in July of 2008, but which was granted cert by the Supreme Court following an appeal from the Department. Thus *Tobin*, like *Shafer*, did not become law until

later, in 2010, and could not be relied upon in argument before the Department, Board, or the Courts).

The case of *Shafer v. Labor & Industries* upon appeal at the Washington State Supreme Court was argued on March 10, 2009 and was not decided until August 13, 2009. The appeal filed by Ms. Leuluaialii in this matter with the Board of Industrial Insurance Appeals was filed on November 26, 2008 from an Order of the Department of Labor & Industries dated October 14, 2008. The issue here is whether the Department Orders dated May 16, 2008 and October 14, 2008 were properly communicated to “an affected party,” meaning “the attending physician.” Claimant contends that these orders were not properly communicated and therefore neither order has become final. While this original appeal was submitted to the Industrial Appeals Judge for a decision based upon certain Stipulated Facts, the *Shafer* decision did not become final and binding until August 13, 2009.

The proposed Decision and Order in this matter which was based upon the Stipulated Facts was issued on June 23, 2009 and the claimant filed a timely Petition for Review. Subsequent to the original Petition for Review, claimant received notice of the final decision of the Supreme Court in the matter of *Shafer v. Labor &*

Industries, 166 Wn. 2d. 710 (decided Aug. 13, 2009). Four days after the Supreme Court decided the *Shafer* case aforementioned, Ms. Leuluaialii filed her Amended Petition for Review, raising the issue of the order not being communicated to her attending physician for the first time. This document became part of the Certified Appeal Board Record, and was duly considered by the Board.

Ms. Leuluaialii submitted evidence that Dr. Vaughn was her attending physician on her claim. She also submitted evidence that Dr. Vaughn's address was not the same address as the one on the final orders closing her claim, both the order of May 16, 2008 and the correcting order of October 14, 2008, which had the name and address of a different attending physician. Interpreting the statute in the light most favorable to the injured worker, with all doubts resolved in favor of the injured worker, the Court should find that the orders closing her claim were not communicated to her attending physician, and thus, her claim was never properly closed.

C. Ms. Leuluaialii's attorneys should be entitled to an award of fees for work done at Superior Court as well as work done at the Court of Appeals.

Rule 18.1 of the Rules of Appellate Procedure provides that if "applicable law grants to a party the right to recover reasonable attorney fees or expenses on review, the party must request the fees or expenses provided in this rule, unless a statute specifies that the request is to be directed to the trial court." RAP18.1

RCW 51.52.130 provides that in worker's compensation cases, if the worker appeals from a decision and order of the Board and the order is reversed or modified and additional relief is granted to the worker, the worker is entitled to attorney's fees for the work done before that court.

Ms. Leuluaialii's attorneys therefore request that this Court overturn the decision of the Superior Court which affirmed the decision of the Board, and that they be awarded reasonable fees for the work done on this appeal before the Court.

VI. CONCLUSION

Ultimately, Ms. Leuluaialii is requesting this Court to overturn the decision of the Superior Court which affirmed the decision of

the Board of Appeals, and to find that the Department had subject matter jurisdiction under RCW 51.32.240 to issue the October 14, 2008 order correcting the May 16, 2008 order which assessed an impairment award for the correct amount, but for an incorrect body part.

Alternatively, under the Supreme Court's ruling in *Shafer*, Ms. Leluaialii also respectfully asks this Court to find that the May 16, 2008 order closing her claim was never properly communicated to her attending physician, as the evidence submitted at the Board level shows, and interpreting the Act in the manner that resolves all doubt in favor of the injured worker.

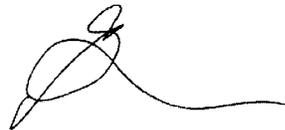
Last, Ms. Leluaialii respectfully asks this Court to grant her an award for attorney's fees for the work done before this Court under the provisions of RAP 18.1 and RCW 51.52.130.

Respectfully submitted this 10th day of June, 2011.

GEORGE M. RIECAN & ASSOCIATES, INC., P.S.



ROBERT S. ALLEN, WSBA# 35958
Attorney for Appellant Leuluaialii



COURT OF APPEALS
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COURT OF APPEALS, DIVISION II
IN AND FOR THE STATE OF WASHINGTON

SINAIPUA L. LEULUAIALII,)
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Plaintiff,)
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v.)
)
DEPARTMENT OF LABOR AND)
INDUSTRIES and FRANCISCAN)
HEALTH SYSTEMS WEST)
)
Defendants.)

NO. 41601-8-II

AFFIDAVIT OF SERVICE

STATE OF WASHINGTON)
) ss.
COUNTY OF PIERCE)

SARA M. MONEY, being first duly sworn on oath, deposes and says:
That she is a legal assistant employed by GEORGE M. RIECAN & ASSOCIATES, INC.,
P.S., attorneys for Plaintiff in the above-entitled matter, and that on the 10th day of June, 2011, she
caused to be served, by Legal Messenger, Certified Mail, or First Class Mail, as indicated,
Appellant's Brief to the following:

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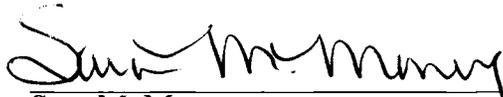
David Ponzoha, Clerk/Administrator
Washington State Court of Appeals, Division II
950 Broadway, Ste. 300 (via E-service 6/10/11)
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Copy to:

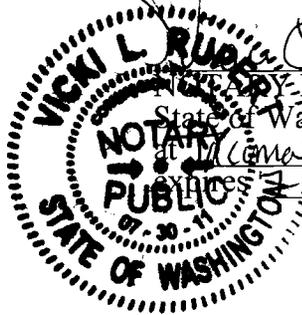
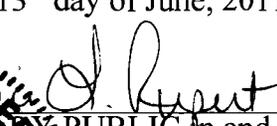
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DATED this 13th day of June, 2011.


Sara M. Money
Legal Assistant to Riecan Law Office

SUBSCRIBED AND SWORN to before me this 13th day of June, 2011.



Vicki L. Ruppel, Notary Public in and for the
State of Washington, residing
at Tacoma, WA. My Commission
Expires 7-30-11

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