Workers' Compensation

Arkansas • Illinois • Iowa • Kansas
Missouri • Nebraska • Oklahoma

MVP Law Seminars • 2021

www.mvplaw.com

ARKANSAS WORKERS' COMPENSATION

I. JURISDICTION

A. Act will apply where:
   1. The injury occurred in the state of Arkansas.
   2. The contract of employment is entered into in Arkansas between an Arkansas resident and an employer who is a resident or who maintains an office in Arkansas exercising general control over the employee, even if the injury occurred in a different state in which both parties contemplated the employment would be performed.
   3. Claimant is entitled to a presumption of jurisdiction, but such presumption is rebuttable. Multiple factors are considered for jurisdiction determinations.

II. ACCIDENTS

A. Compensable Injury Ark. Code Ann. § 11-9-102(4)(A)
   1. Specific Incident – Claimant must prove each element by a preponderance of the evidence:
      a. An injury arising out of and in the course of employment;
         i. "Arising out of" refers to the cause of the accident. An injury arises out of employment if the employee is carrying out the employer's purpose or advancing the employer's interests.
         ii. "In the course of" refers to the time, place and circumstances of the accident. The accident must occur within the time and space boundaries of the employment
      b. That the injury caused internal or external harm to the body which required medical services or resulted in disability or death;
         i. An aggravation of a pre-existing condition can be compensable if all of these elements are met for the aggravating incident
      c. Medical evidence supported by objective findings, as defined in Ark. Code. Ann. 11-9-102(16);
      d. That the injury was caused by a specific incident identifiable by time and place of occurrence.
   2. Gradual Onset/Repetitive Motion: Injuries caused by rapid repetitive motion (carpal tunnel specifically included) or gradual onset injuries to the back or hearing loss require proof of the following elements:
      a. An injury arising out of and in the course of employment;
      b. That the injury caused internal or external harm to the body which required medical services or resulted in disability or death;
      c. The injury was the major cause of the disability or need for treatment;
      d. Medical evidence supported by objective findings.
   3. Mental illness Ark. Code Ann. § 11-9-113

a. For mental illness to be a compensable injury it must be caused by physical injury to the employee's body, demonstrated by a preponderance of the evidence, and diagnosed by a licensed psychiatrist or psychologist.
b. Exception: victims of crimes of violence.
c. Maximum compensation is 26 weeks.

4. Heart or cardiovascular injury, accident, or disease Ark. Code Ann. § 11-9-114
   a. Compensable only if an accident is the major cause of the physical harm.
   b. The employee must show that the exertion of the work necessary to precipitate the disability or death was extraordinary and unusual in comparison to the employee's usual work or that an unusual and unpredicted incident occurred which was the major cause of the physical harm and stress must not be considered.
5. Hernia Ark. Code Ann. § 11-9-523
   a. Employee must show that the hernia occurred immediately following and as a result of sudden effort, severe strain, or the application of force directly to the abdominal wall; that there was severe pain in the hernia region that caused the employee to immediately cease work; that the employee gave the employer notice within 48 hours afterward and that medical attention was required within 72 hours.

B. Occupational Disease Ark. Code Ann. § 11-9-601
1. Occupational Disease is defined as any disease that results in disability or death and arises out of and in the course of the occupation or employment or naturally follows or results from a compensable injury.
2. There must be a causal connection between the occupation and the disease established by a preponderance of the evidence.
3. An occupational disease is characteristic of an occupation, process or employment where there is a recognizable link between the nature of the job performed and an increased risk in contracting the disease in question.
4. The test of compensability is whether the nature of the employment exposes the worker to a greater risk of the disease than the risk experienced by the general public or workers in other employments.
5. The amount of compensation will be based on the average weekly wage of the employee when last exposed to the occupational disease.

III. NOTICE Ark. Code Ann. § 11-9-701

A. Notice of the accident should be given immediately after it occurs and must be reported on the appropriate form prescribed or approved by the Commission (Form N).

B. Failure to give notice will not bar a claim if:
1. The employer had knowledge of the injury; or
2. If the employee had no knowledge that the condition or disease arose out of and in the course of employment; or

3. If the Commission excuses the failure due to a satisfactory reason that the notice could not be given.

IV. REPORT OF INJURY Ark. Code Ann. § 11-9-529

A. Employers must file a report of injury (Form 1) with the Arkansas Workers' Compensation Commission within 10 days of receiving notice or knowledge of the injury.

B. The report filed with the Commission must include:
   1. Name, address, business of the employer;
   2. Name, address, occupation of employee;
   3. Cause and nature of the injury; and
   4. Date, time and location of the injury.

C. Failure to file a report could result in a $500 fine.

V. CLAIM FOR COMPENSATION

A. A claim for an injury other than an occupational disease must be filed within 2 years from the date of the injury unless compensation has been paid, in which case a claim for additional compensation must be filed within 1 year from the date of the last payment of compensation or 2 years from the date of the injury, whichever is greater.
   1. The date of the injury is defined as the date of the occurrence of the accident from which a compensable injury results.

B. Claims based on occupational diseases must be filed within 2 years from the date of the last injurious exposure to the hazards of the disease. The statute of limitations does not begin to run until the employee knows or should be reasonably expected to be aware of the extent or nature of the injury.

C. If the employee has not made a request for a hearing within six months of filing a claim for compensation the employer may move to dismiss the claim without prejudice.

D. Failure to file a claim within the statutory time limits is not a bar to the right to file a claim unless the employer objects at the first hearing on the claim.

E. Benefits not claimed on the Form C are barred by the SOL, if later claimed, but more than 1 year from last payment of compensation. *Flores v. Wal-Mart Dist. and Claims Mgmt. Inc.,* 2012 Ark. App. 201.

VI. INTENT TO ACCEPT OR CONTROVERT CLAIM Ark. Code Ann. § 11-9-803

A. Employer must file a statement of its intent to accept or controvert a claim (Form 2) within fifteen days of the date upon which it receives notice of the alleged injury.

B. Employer may request a time extension if it has made a good faith effort to obtain medical records, but has been unable to do so and is therefore unable to determine the validity of the employee's claim.

C. Note that this step must be done within fifteen days of the injury, **not** within fifteen days of the claim for compensation, so that this step will typically be required before the employee has even filed a claim for compensation.

VII. MEDICAL TREATMENT Ark. Code Ann. § 11-9-508

A. Employer has the right to select the initial treating physician. If the employer has contracted with a certified managed care organization, then the employer has the right to select the initial primary care physician from among those in the organization.

B. However, the employee may request a one-time change of physician from the employer or carrier.
   1. If the employee's request for a change of physician is denied, the employee can petition the Commission and if the Commission agrees, they may select the physician if they do not agree with the employee's choice.
   2. When the employee petitions for a change of physician, the new physician must be either:
      a. Associated with the managed care entity chosen by the employer, or
      b. The regular treating physician of the employee provided the following factors are met:
         i. the physician maintains the employee's medical records;
         ii. the employee has a bona fide doctor-patient relationship with they physician;
         iii. there is a history of regular treatment prior to the onset of the compensable injury;
         iv. the primary care physician agrees to refer the employee to the managed care entity for specialized treatment; and
         v. the primary care physician agrees to comply with the rules, terms, and conditions regarding services performed by the managed care entity chosen by the employer.

C. Treatment furnished by any physician other than the ones selected according to these methods, except emergency treatment, will be at the employee's expense.
   1. Exception: If the employer does not deliver to the employee, either in person or by certified mail, a copy of a notice which explains the employee's rights and

responsibilities concerning a change of physician, then the changes of physician rules do not apply and the employer will be responsible for the unauthorized treatment.

D. If the employer fails to provide prompt medical services within a reasonable time, the Commission may direct that the injured employee obtain the medical service at the expense of the employer.

VIII. VOCATIONAL REHABILITATION Ark. Code Ann. § 11-9-505

A. Upon a finding by the commission that a vocational rehabilitation program is reasonable, an employer will be liable to an employee for vocational rehabilitation costs if the employee:
   1. Is entitled to receive compensation benefits for permanent disability; and
   2. Has not been offered an opportunity to return to work or reemployment assistance.

B. Employer's responsibility for payments for the program will not exceed 72 weeks.

C. Employee will not be required to enter a program against his or her consent.
   1. If employee waives rehabilitation or refuses to participate in an offered program, the employee will not be entitled to benefits beyond the established percentage of permanent physical impairment.

D. Employee must request the program by filing a request with the Commission prior to a determination of the amount of permanent disability benefits payable to the employee.

IX. AVERAGE WEEKLY WAGE Ark. Code Ann. § 11-9-518

A. Computed based on the contract of hire in force at the time of the accident, considering the fifty-two weeks prior to the accident, including the reasonable value of board, rent, housing, lodging, or similar advantage received from the employer as well as tips and commissions.

B. Piece-basis employees: divide the earnings by the number of hours required to earn those wages during the fifty-two weeks preceding the week in which the accident occurred, then multiply this hourly wage by the number of hours in a full-time workweek.

C. Overtime: add to the regular weekly wages, compute by dividing the overtime earnings by the number of weeks worked by the employee.

X. DISABILITY BENEFITS

A. Temporary Total Disability (TTD) Ark. Code Ann. §§ 11-9-501(b), 11-9-519
   1. Compensation rate is two-thirds of average weekly wage (AWW) up to statutory maximum.
   2. If an injured employer refuses suitable employment he loses any entitlement to compensation unless the Commission determines the refusal is justifiable.
   3. Waiting period:
      a. For the first seven calendar days, no TTD is due.
      b. For more than seven, but less than fourteen days, only the second week is due.
      c. For more than fourteen days of disability, go back to the first day of disability.
      d. The waiting period does not include the date of injury.
   4. TTD is calculated using the calendar week with each day being one-seventh of the week.
   5. Failure to pay TTD without an award within fifteen days after it becomes due is an eighteen percent penalty which must be paid at the same time as the installment unless notice of controversion is filed or an extension is granted.
   6. If a TTD installment payable under an award is not paid within fifteen days after it becomes due, there is a twenty percent penalty.
   7. Willful failure to pay a benefit results in a penalty up to thirty-six percent.

B. Temporary Partial Disability (TPD) Ark. Code Ann. § 11-9-520
   1. Compensation rate is 2/3 of the difference between the employee's average weekly wage prior to the accident and his wage-earning capacity after the injury.

C. Permanent Partial Disability (PPD) Ark. Code Ann. §§ 11-9-501(d)(1), 11-9-521
   1. Compensable injury must be the major cause (more than 50%) of the injury for Claimant to receive permanent benefits.
   2. Compensation rate is 75% of TTD rate up to the statutory maximum if the TTD rate is $205.35 or greater. If TTD rate is below $205.35, PPD rate is 2/3 of average weekly wage.
   3. Permanent partial disabilities not listed in the statutory schedule will be apportioned to the body as a whole with a value of four hundred fifty weeks.
   4. In claims for disability in excess of permanent partial impairment for unscheduled injuries (wage loss claims), the Commission may take into account the employee's age, education, work experience, and other matters that may affect his future earning capacity.
   5. Compensation is allowed after twelve months after the injury, for serious and permanent facial or head disfigurement for not more than $3,500.
   6. The clinical impairment rating must be pursuant to the AMA Guides to the Evaluation of Permanent Impairment (4th Edition).

a. If the employee is back to work, only the clinical rating is due.
b. If the employee is unable to return to work, the rating is negotiable and can be awarded by the ALJ.

7. PPD payments should start from the date the rating is given and notification in writing should be given to the injured employee.

D. Permanent Total Disability (PTD)

1. Permanent total disability means the inability because of compensable injury or occupational disease to earn any meaningful wages in the same or other employment.
2. Compensation rate is 2/3 of the average weekly wage.
3. The employer or carrier may, annually, require the injured worker receiving permanent total disability benefits to certify that he is permanently and totally disabled and not gainfully employed.
4. As of January 1, 2008 the cap for PTD is 325 times the maximum total disability rate established at the date of injury.

E. Death

1. For deaths occurring as the result of an injury that occurred on or after July 1, 1993, the employer is responsible for funeral expenses of $6,000 or less.
2. There is a rebuttable presumption that death did not result from the injury if:
   a. death does not occur within one year from the date of the accident; or
   b. within the first three years of the period for compensation benefits.
3. Compensation for death of an employee is payable to the dependents in the following percentages of the average weekly wage and in the following order of preference:
   a. Widow/Widower with no children: 35% paid until his/her death or remarriage;
   b. Widow/Widower with children: 35% paid until his/her death or remarriage and15% for each child;
   c. One child with no widow/widower: 50%;
   d. More than one child with no widow/widower: 15% for each child and 35% to the children as a class to be divided equally among them;
   e. Parents: 25% each;
   f. Siblings, grandchildren, grandparents: 15% each.
4. If a spouse remarries before complete payment of benefits, he/she must be paid a lump sum equal to compensation for 104 weeks.
5. Benefits to children will terminate at age eighteen unless the child is a full-time student under the age of twenty-five.
6. Incapacitated dependants are entitled to compensation regardless of age or marital status.

F. Illegally Employed Minor
    1. Minors employed in violation of federal or state statutes pertaining to minimum ages for employment of minors are entitled to double the statutory amounts of compensation or death benefits.
    2. This provision applies unless the minor misrepresented his or her age, in writing, to the employer.

G. Attorney's Fees Ark. Code Ann. 11-9-715
    1. Capped at 25% of compensation for indemnity benefits.
    2. Attorney's fees are not payable on medical benefits.
    3. Where the Commission determines that a claim has been controverted, in whole or part, attorney's fees are paid ½ by employer in addition to compensation awarded and ½ by the claimant out of compensation payable to them.

XI. PROCEDURE

A. Pre-Injury Posting (Form P)
    1. Employers should have Form P displayed in a conspicuous place to instruct employees in how to deal with an injury.

B. Employee's Notice of Injury (Form N)
    1. Employee is required to fill out Form N and provide notice of his injury to the person and place specified by the employer.
    2. Employer is not responsible for any benefits to the employee incurred prior to notification of the injury, except for emergency treatment that occurs outside the normal business hours of the employer, so long as a report of injury is made the next day.
    3. Employee can be excused for failure to file Form N if:
        a. the injury renders the employee incapable of informing the employer of it;
        b. the employee did not know a condition arose out of employment; or
        c. the employer had actual knowledge of the injury.

C. Employer's Report of Injury (Form 1)
    1. Employer must report an employee's injury to the workers' compensation commission within ten days from receipt of notice of actual knowledge using Form 1.
    2. Failure to do so may result in a fine up to $500.

D. Claim for Compensation (Form C)
    1. Employee must file a claim for compensation using Form C within the limitations period, which is 2 years from the date of injury or 1 year from the last payment of compensation.

2. The claim will be assigned to one of six geographic districts throughout the state, based on the county in which the injury occurred or the district in which the respondent's place of business is located if the injury occurred outside the state.
3. Ark. Code Ann. § 11-9-704. The Commission must notify the employer and any interested parties that an employee has filed a Claim for Compensation within ten days of such a filing.
4. Ark. Code Ann. § 11-9-702. If the employee fails to request a hearing within six months of filing his or her claim the claim may, upon motion and hearing, be dismissed without prejudice, allowing the employee to refile his claim within the two-year statute of limitations.

E. Employer's Response (Form 2)
1. Employer must file a statement of its intent to accept or controvert a claim (Form 2) within fifteen days of the date upon which it received notice of the alleged injury.
2. Form 2 may be required well before the employee files a Form C.
3. Employer may request a time extension if a good faith, but unsuccessful effort has been made to obtain medical records rendering the employer unable to determine the validity of an employee's claim.

F. Payment of Benefits
1. The first installment of compensation must be paid on the fifteenth day after the employer received notice of the injury, with payments to continue every two weeks thereafter.

G. Disputed Claims
1. Preliminary Conference
    a. Mediation Conferences will be held in all cases in which the amount in dispute is less than $2,500.
    b. For cases in which the amount in dispute is more than $2,500 the parties may request a voluntary mediation if all parties agree.
    c. The conference will be informal, nonbinding, and confidential, by telephone or in person.
    d. Attendance by the parties or a representative is required and the mediator is authorized to compel attendance, however the mediator is not authorized to compel settlement.
    e. Following the conference, the Report of Mediation Conference (Form R) is placed in the file and copies are sent to all the parties.
2. Depositions
    a. Any party may conduct depositions <u>after</u> the claim has been controverted by the filing of Form 2, however prior to the time a case has been controverted, the Commission may order depositions for good cause shown and upon application of either party.
3. Settlement

a. If both parties agree to a settlement a joint petition must be filed with the Commission.
b. The Commission will hear the petition, take testimony, and make investigations to determine whether to allow the final settlement.
c. Neither party may appeal an order or award denying a joint petition, however the denial is made without prejudice to either party.

4. Hearing
    a. Either party may file an application for a hearing that clearly identifies the specific issues of fact or law in controversy and the applying party's contentions.
    b. If ordered, the Commission must give interested parties ten days notice of the hearing.
    c. The hearing will be held in the county where the accident occurred, or the county of the employer's residence or place of business if the injury occurred outside the state.
    d. Evidence may include verified medical reports provided the party using the reports has given opposing counsel notice and copies of all records and reports within seven days of the hearing.
    e. Expert testimony is only permissible if such testimony complies with the requirements of Daubert and Kumho.
5. Award
    a. The order denying the claim or making the award will be filed in the office of the Commission and a copy will be sent to each party.
6. Appellate Process
    a. Full Workers' Compensation Commission
        i. 30 days from the date of receipt of the order or award to file application for review
        ii. Will review the evidence, or hear the parties, their representatives, and witnesses.
    b. Court of Appeals
        i. 30 days from the date of receipt of the order or award to file notice of appeal
        ii. Notice filed in office of commission
        iii. Court will review only questions of law and may modify, reverse, remand for rehearing, or set aside the order or award upon any of the following grounds, but no others:
            (a.) The commission acted without or in excess of its powers
            (b.) The order or award was procured by fraud
            (c.) The facts found by the commission do not support the order or award
            (d.) The order or award was not supported by substantial evidence of record

XII. DEFENSES

A. Assault
   1. Employee's claim will be barred if it occurred as a result of an assault absent a showing by a preponderance of the evidence that the incident arose out of a work related animus or hostility between the claimant and the co-worker who caused the assault.

B. Horseplay
   1. An injury that occurs as a result of horseplay will not be compensable except as to innocent victims of the playing.
   2. Arkansas statutes and cases do not define horseplay, but find it synonymous with the terms "skylarking," or "rough or boisterous play." *Morales v. Martinez,* 88 Ark. App. 274.

C. Going and Coming Rule
   1. Precludes recovery for an injury sustained while the employee is going to or returning from his place of employment.
   2. Premises exception no longer exists in Arkansas. The 1993 Act excludes from compensation injuries that occur "at time when employment services were not being performed."
      a. Merely walking through an employer's parking lot will not qualify as performing "employment services" and therefore a claim for injury arising out of that activity will likely be precluded. *See Hightower v. Newark Public School System*, 57 Ark. App. 159.
   3. The rule does not preclude benefits where the journey itself is part of employment services, such as in the case of delivery drivers.
   4. Dual Purpose Exception
      a. An injury occurring during a trip that serves both a business and personal purpose is within the course of employment.
         i. A trip that involves the performance of services for the employer which would have caused the trip to be taken by someone else falls under this exception
      b. Applies to out of town trips, trips to and from work, and miscellaneous errands such as visits to bars and restaurants if motivated in part by the intention to transact business there.
      c. Exception will not apply to identifiable deviations from the business trip for personal reasons until the employee returns to the route of the business trip, unless the deviation is so small as to be disregarded as insubstantial.

D. Recreational or social activities
   1. An employee injured while engaging in or performing or as a result of engaging in or performing any recreational or social activities for the employee's personal pleasure is precluded from receiving compensation benefits.

E. Employment services were not being performed, employee had not yet been hired or employment relationship had terminated.

F. Intoxication Ark. Code Ann. § 11-9-102(4)(B)(iv)
   1. An injury "substantially occasioned" by the use of alcohol or drugs is not compensable.
   2. The mere presence of alcohol or drugs creates a rebuttable presumption that the accident was substantially occasioned by the use of the drugs or alcohol.
   3. By performing services for the employer, the employee has impliedly consented to reasonable drug and alcohol testing for the presence of these substances in the employee's body at the time of the accident and refusal to test precludes the employee from receiving benefits unless he proves it did not substantially cause the injury.
   4. The employee must prove by a preponderance of the evidence that the alcohol or drugs did not substantially occasion the accident.
   5. If a reasonable suspicion of alcohol exists at the time of the accident testing must be done within eight hours.
   6. If a reasonable suspicion of drugs exists at the time of the accident testing must be done within thirty-two hours.

G. "Shippers Defense" from *Shippers' Transport of Georgia v. Stepp,* 265 Ark. 365.
   1. A false statement in an employment application will bar workers' compensation benefits if the following conditions are shown:
      a. The employee knowingly and willfully made a false representation as to his or her physical condition;
      b. The employer relied upon the false representation;
      c. The reliance upon the false misrepresentation was a substantial factor in hiring the employee; and
      d. There is a causal connection between the false representation and the injury.
   2. For the defense to apply, the questions asked on the employment application must request factual information, not an opinion.

RECENTLY ASKED QUESTIONS IN ARKANSAS

FROM ISSUES ADDRESSED IN RECENT ARKANSAS CASES

Q. ***Does an employer's general offer of light-duty work within a claimant's restrictions constitute a "bona fide" offer that meets workers' compensation law standards if it lacks information regarding the position and its pay rate?***

A. No. The claimant in *Calhoun* was a part-time employee whose job duties included loading a van and delivering food to the elderly. Claimant sustained injuries while driving an employer-owned van that overturned in an accident on January 13, 2016. Claimant was not restrained at the time and sustained a fractured neck at C1 through C3 with temporary paralysis, a closed-head injury and laceration to the scalp, blunt-chest trauma with a collapsed lung, and abdominal injuries. On January 14, 2016, Claimant underwent neck surgery and spent the following year in extensive treatment. Claimant was released at maximum medical improvement by Dr. Kiser on February 27, 2017 with a 24 percent permanent partial-impairment rating to the whole body, which is not disputed by either party. Dr. Kiser noted on March 1, 2017 that any return to work for Claimant would have to consist of a sit-down job at a chair or wheelchair level. The report further stated that Claimant would not be able to carry objects or drive a vehicle.

On March 3, 2017, the insurance adjuster sent Claimant's attorney a fax message including Dr. Kiser's report which released Claimant to MMI and a message stating that his employer could accommodate his restricted duty and had immediate work available. The fax message included a request for Claimant's attorney to notify Claimant to contact his employer for his schedule, and a note that PPD benefits would be initiated. On June 15, 2017, after approximately 3 months with no response, the insurance adjuster sent a similar letter to Claimant's personal address and requested he contact his employer by June 21, 2017 to advise them of his decision to begin light-duty work.

Claimant testified that he did call and talk to his employer, but he did not ask specifics about the job offered and informed his employer that he was in too much pain to work. Employer's testimony confirmed that Claimant called them upon receipt of the second letter. Employer further testified that they did not relay the details regarding the job requirements because they wanted to get Claimant's input on his abilities and disabilities to customize the job accordingly. Employer recalled the job available was as a greeter and was sedentary in nature but did not offer testimony as to the position's anticipated weekly wages.

The Administrative Law Judge found that Claimant proved he was entitled to a 60 percent wage-loss award in addition to his 24 percent anatomical-impairment rating. The ALJ determined that Employer did not make a bona fide job offer because the position and wages offered were not clear. Employer appealed, arguing that they did extend a bona fide offer of employment through the letters sent to Claimant and his

attorney and the subsequent telephone conversation. The Commission concluded Employer made a bona fide and reasonably obtainable offer for Claimant to be employed at wages equal to or greater than his average weekly wage. The Court of Appeals reversed the Commission's decision that a bona fide offer of employment was made by Employer and remanded for an award of benefits.

The Court of Appeals determined that, when offering a light-duty work position to a claimant to accommodate their restrictions, an employer must include specific information about the new position and pay rate to constitute a bona fide offer that meets workers' compensation law standards.

Calhoun v. Area Agency on Aging of S.E. Arkansas, 618 S.W.3d 137 (Ark. 2021).

Q*. Does an employer's timely and voluntary acceptance and initiation of payment of an impairment rating lower than the claimant's preferred rating constitute a controversion under the law entitling a claimant to additional attorney's fees?*

A. No. In *Eldridge*, the claimant sustained a compensable left-knee injury on July 26, 2016, while working as a quality-control auditor in the mining and metal-diecasting industry for the employer. The employer initially provided medical treatment and temporary total-disability (TTD) benefits for Claimant's left-knee injury. Following a hearing on March 14, 2017, the administrative law judge issued an Opinion that (1) ordered the employer to pay for related medical treatment after the November 14, 2016 change-of-physician order was granted; (2) ordered TTD benefits to be paid for a period certain; and (3) awarded the maximum statutory allowance for attorney's fees on the benefits awarded. The Commission affirmed the ALJ's decision as modified, finding that Claimant was entitled to additional TTD benefits for some of the time periods in question, but not all.

After receiving additional medical treatment, Claimant underwent evaluation to determine his anatomical-impairment rating. He was given a 50 percent rating that included a pain component. Thereafter, the employer sought an independent medical examination (IME) to obtain a rating that excluded subjective complaints of pain. The IME rating was assessed as a 37 percent anatomical-impairment rating to the left lower extremity. The employer accepted the IME rating and timely and voluntarily awarded benefits to the claimant associated with the 37 percent rating.

The claim came before the ALJ again on August 6, 2019, where testimony regarding Claimant's entitlement to additional medical treatment, an impairment rating greater than 37 percent, and an attorney's fee was heard. The ALJ issued an Opinion on November 4, 2019 that awarded Claimant the additional medical treatment requested, but found Claimant was only entitled to a 37 percent anatomical-impairment rating; thus, no award of attorney's fees was granted. The Commission affirmed in an opinion filed June 18, 2020.

The Court of Appeals applied Ark, Code Ann. § 11-9-715(a) to support their finding that Claimant was not entitled to additional attorney's fees. Under this rule, a fee is payable

from the employer or their insurance carrier only if the benefits are controverted and awarded. The claimant argued the benefits were controverted because the award was based on the IME rating instead of their preferred rating. The Court rejected this argument and found substantial evidence to support the contrary. Specifically, the Court found that timely and voluntary acceptance and payment of an impairment rating lower than Claimant's preferred rating does not constitute a controversion under the law, and therefore, Claimant's attorney was not entitled to a fee.

Eldridge v. Pace Industries, LLC, 2021 Ark. App. 245 (Ark. App. 2021).

Q. ***Is a diagnosis of depression and PTSD by a licensed counselor and psychiatrist, the onset of which was specifically noted as related to a work-injury, sufficient in proving a compensable mental injury?***

A. No. The claimant in *Bronco Industrial Services, LLC v. Brooks* worked for Bronco as a laborer tearing down and repairing mills. On June 6, 2016, Claimant was instructed by his employer to drive a pickup truck. Claimant parked the truck on an incline when he reached his destination and as he exited the vehicle, the truck rolled backwards and knocked him to the ground. Claimed stated that he had go to the emergency room after work because his safety supervisor refused to take him or let him go to the hospital for immediate treatment when he reported his injury to them. He was diagnosed with chest and leg contusions. Over the next year and a half, Claimant was diagnosed and treated for the contusions as well as reflex sympathetic dystrophy.

On January 10, 2018, Claimant saw a licensed clinical social worker and a psychiatrist and was diagnosed with "Major Depressive Disorder, Single Episode, Moderate" and "post-traumatic stress disorder, unspecified." Claimant testified he has had mental-health issues since the early 1990's, but it was noted in the January 10, 2018 report that both diagnoses became apparent after the alleged work-injury at Bronco.

The Court of Appeals found that the evidence did not demonstrate the depression and PTSD diagnoses were causally related to his compensable physical injuries. Instead, they found his mental injury was related to a confrontation he had with his supervisor shortly after his injury, stress related to his legal representation, and trust issues as a result of living in a "high crime area." Claimant testified that he sought mental-health treatment because of "flashbacks," but the Court found the flashbacks were not causally related to his compensable injuries. Additionally, the Court noted that the medical record referencing the depression was due to adjustment to his injury and life change was found under a section entitled "Client Self-Assessment." The Court discussed *Amlease, Inc. v. Kuligowski*, 957 S.W.2d 715 (Ark. App. 1997), which held that mental injury must be causally related to the claimant's physical injuries, and not external factors such as environmental stress or preexisting trust issues. As such, the Court affirmed the Commission's finding that Claimant failed to prove a compensable mental injury.

Bronco Indus. Services, LLC v. Brooks, 2021 Ark. App. 279 (Ark. App. 2021).

Q. ***Whether an injury that occurs while walking to work from a parking lot adjacent to the employer's premises is compensable when the employee was not performing work duties, but was required to park there by the employer.***

A. No. The claimant in *Pratt* worked as a sales representative at a car dealership from 8:00 a.m. to 8:00 p.m. in the summer. His job duties included meeting and greeting customers, showing customers vehicles, gathering paperwork for the sale of vehicles, detailing vehicles, and other duties relating to vehicle sales. When he was not making sales, he was expected to walk the parking lots to ensure everyone was taken care of. On April 11, 2019, the claimant arrived at work and parked in the designated parking section located on the adjacent car dealership's premises. As he was crossing the culvert that divided his designated parking lot and his employer's parking lot he fell backwards and injured his knee.

At a hearing before the administrative law judge on September 18, 2018, Claimant's co-worker, Mr. Neilson, testified on his behalf. He stated that he worked at Jeep as a car salesman with Claimant and that he and others parked at GMC, which was approximately 100-150 feet from Jeep. He testified that he and others would cross the rocky culvert to get from one lot to the other and denied ever being instructed not to cross the culvert prior to Claimant's injury. He stated that after Claimant's injury, however, several meetings were held to inform employees that disciplinary actions would be taken if they were caught crossing the culvert. Mr. Neilson testified that he had no duties before clocking in and that he was not required to cross the culvert to clock in, but he witnessed employees do it daily. Additionally, he stated that they could sell cars on any of the lots. Claimant testified that he had to park at GMC because of limited space in Jeep's lot and Mr. Neilson confirmed this, stating that workers could park anywhere on two rows of the GMC lot.

Claimant testified that after he was released to return to work, he texted his employer and asked when he could go back to work. Claimant never heard back from his employer after he asked to return. He testified that he was not clocked in or performing work duties at the time of his fall. Claimant stated that he could have taken the sidewalk instead of crossing the culvert and would have arrived to work on time, but that he did the latter since it was faster and he was never instructed against doing so by his employer. He agreed that taking the sidewalk was safer than crossing the culvert. Claimant refused to sign the reprimand following his fall because he was never "pre-warned" about crossing the culvert. Additionally, Claimant testified that he was asked by his employer to sell vehicles on both lots.

Claimant's supervisor testified that he told Claimant that he was not supposed to cross the culvert when he reported his injury. He stated that there was a rule against crossing the culvert that applied to all employees in place prior to the claimant's fall. He further stated that this rule was mentioned in the morning sales meetings several times and that Claimant's crossing the culvert was in violation of Jeep's verbal policy, and as such, Claimant was written up for doing so. The general manager, Mr. Wichman, also testified that a policy against crossing the culvert was in place prior to Claimant's injury and that it was reiterated to the employees during several meetings. Claimant did not deny that the policy was in place but denied ever hearing about it. Two of Claimant's co-workers testified that employees were informed about the policy

many times in various meetings, but they witnessed other employees crossing the culvert anyways.

The Court of Appeals found that Claimant failed to prove his injury occurred in the course and scope of his employer and denied compensation. Although testimony from multiple Jeep employees confirmed that sales representatives were expected to speak to customers even if they were not clocked in, there was no testimony that Claimant was assisting a customer when his injury occurred. Claimant argued that his injury was compensable because he was required to park in GMC's lot, and by doing so, he was carrying out Jeep's purpose or interests. The Court rejected this argument and found that Claimant's injury would still not be compensable if he had fallen in the parking lot or on the sidewalk leading to Jeep since he was not performing employment services. The Court stated that "merely parking in a designated parking area opened to the public is not enough to lead us to hold that [Claimant] was performing employment services once parked in the lot."

Pratt v. Bentonville, 2021 Ark. App. 184 (Ark. App. 2021).

Q. *Whether an injury that occurs while the claimant is residing on the employer's premises, when such residence was permitted but not required by the employer, is compensable.*

A. No. The claimant in *Lopez* worked in the horse-racing industry for eighteen years and was hired by James Divito Racing Stable in February 2018 as a "hot walker." As a hot walker, Claimant walked the horses after training sessions or races to cool them down. Claimant worked from 5:30 a.m. to 10:30 a.m. each morning and worked approximately 25 races during the four-month racing season. He was paid $350 per week and was provided free housing at the horse track above the stables. The claimant agreed that he was not required to live at the stables but stated he could not afford to live elsewhere. Additionally, the employer did not pay for his employees or his horses to reside at the stable.

The night before the injury, Claimant went out to eat with a friend, came back to his room at the stable, and fell asleep around 11:30 p.m. His shift the following morning started at 6:00 a.m., but he was awoken by a fire and the smell of smoke around 5:45 a.m. Claimant was unable to open his door because of the fire, so he jumped approximately ten feet to the ground out of his second-story window to evacuate. As a result, he suffered a burst fracture of his T12 vertebra and was transported by ambulance to the hospital. He underwent surgery and spent four days in the hospital. The injury prevented Claimant from being able to work for over ten months, and all subsequent attempts to work were unsuccessful due to pain and numbness.

The Court of Appeals held that Claimant's injury was not compensable because he was not providing employment services at the time of the injury and was not required to live at the stable as a condition of his employment. Instead, the Court determined Claimant willfully chose to stay there because it was free and convenient. Because the claimant was not doing anything to further the interest of his employer at the time of the injury, the Court of Appeals found that he failed to prove that his injury was compensable.

Lopez v. James Divito Racing Stable, 2021 Ark. App. 257 (Ark. App. 2021).

Q. *Does the introduction of objective medical evidence of a second, work-related injury, where there is insufficient evidence of medical causation, suffice to prove the claim is compensable, when the first injury has been accepted by Respondents?*

A. No. The claimant in *Osburn* drove a truck and made deliveries for Pepsi. On January 2, 2015, Claimant sustained a compensable right shoulder injury for which Pepsi accepted and paid all related benefits. Claimant later claimed he sustained a second work-related injury to his left shoulder and neck on May 16, 2016. Pepsi controverted the compensability of the left shoulder and neck claim and the administrative law judge denied compensability, finding Claimant failed to prove the left shoulder and neck issues were related to his work activities on May 16, 2016. Instead, the medical findings were held by the ALJ to have been caused by degenerative and arthritic conditions that had no causal connection to his work activities.

Claimant alleged to have sustained a work-related left-shoulder and back injury on May 16, 2016, the day he returned to driving a truck for Pepsi. On that day, Claimant stated he was opening the back door of an eighteen-wheeler during a delivery and felt a burning pain in his neck. He claimed that this incident aggravated preexisting neck pain and resulted in left-shoulder pain. In reporting the incident to his supervisor, the claimant stated that he told his supervisor he believed he pulled a muscle in his left shoulder. His supervisor disputed this claim, stating the claimant told him the incident caused a reinjury to his *right* shoulder. Claimant sought medical treatment and eventually underwent surgery, which he stated relieved the neck and left shoulder pain.

Although Claimant presented objective medical findings that supported his left-shoulder and neck injuries, the Court of Appeals found that he failed to prove causation between the findings and work-related activity. Several references in Claimant's medical records showed his complaints of left-shoulder and neck pain began in April 2016, the month prior to the alleged work incident. In a medical questionnaire dated July 27, 2016, Claimant himself noted his left-shoulder and neck pain were not workers' compensation injuries. Additionally, the MRI report stated Claimant had "severe…degenerative cervical disk disease." The Court determined that such evidence displayed a substantial basis for denial of benefits on the grounds that Claimant failed to prove his injuries were caused by his employment.

Osburn v. Pepsi Cola Metro Bottling Co., 2021 Ark. App. 157 (Ark. App. 2021).

Q. *May a claimant properly use the Declaratory Judgements Act to compel discovery outside of the Workers' Compensation Act?*

A. No. In *Esterline Technologies Corporation v. Brownlee*, the claimant was injured in an explosion at an aerospace and defense company and was provided workers' compensation benefits for his injuries. However, the claimant sued his employer, the employer's parent corporation, and a co-employee in civil court seeking a declaratory judgment regarding the duties of the defendants named in the suit. The claimant also requested that the circuit court construe several contracts, which the claimant then

failed to produce. The defendants initially filed an answer and joint motion to dismiss, which was denied by the circuit court. Therefore, the defendants were required to produce thousands of pages of documents to the claimant. A second motion to dismiss was also denied and because the defendants could not appeal the denial and alleged the circuit court had no jurisdiction over the claim, they filed a writ of prohibition with the Supreme Court.

After examining the pleadings, the Supreme Court reiterated the well-established principle that the rights and remedies established under the Workers' Compensation Act "shall be exclusive of all other rights and remedies of the employee." The claimant argued that the exclusivity provision did not apply as he was not seeking monetary recovery but was rather seeking declaratory judgement of the defendants' legal relationships, rights and obligation under certain contracts, and discovery. However, the Supreme Court held that because a declaratory judgment was a "remedy," that it was not available to the claimant because the remedies provided under the Act were exclusive. Therefore, it granted the defendants' writ of prohibition.

Esterline Techs. Corp. v. Brownlee, ___ S.W.3d ___, 2021 Ark. 33, (Ark. 2021).

Q. *Does evidence of marijuana in a claimant's system at the time of the accident allow the employer a defense to workers' compensation benefits?*

A. Yes. Under Ark. Code. Ann. § 11-9-102(4)(B)(iv), a "compensable injury" does not include:

> (iv)*(a)* Injury where the accident was substantially occasioned by the use of alcohol, illegal drugs, or prescription drugs used in contravention of physician's orders.
>
> *(b)* The presence of alcohol, illegal drugs, or prescription drugs used in contravention of a physician's orders shall create a rebuttable presumption that the injury or accident was substantially occasioned by the use of alcohol, illegal drugs, or prescription drugs used in contravention of physician's orders.
>
> *(c)* Every employee is deemed by his or her performance of services to have impliedly consented to reasonable and responsible testing by properly trained medical or law enforcement personnel for the presence of any of the aforementioned substances in the employee's body.
>
> *(d)* An employee shall not be entitled to compensation unless it is proved by a preponderance of the evidence that the alcohol, illegal drugs, or prescription drugs utilized in contravention of the physician's orders did not substantially occasion the injury or accident.

In *Blair*, the claimant was hired four days before her work injury and was transferred into the cutting department on her second day of work. On the date of accident, one of the cutting machines became jammed and after claimant thought she turned the machine off, she reached under the guard in between the blades of the machine to unjam it. At that point, one of the blades activated and cut off one of her fingers. The claimant was given a post-accident drug test which was positive for marijuana metabolites. Therefore, the employer was entitled to the above rebuttable presumption

that the claimant's injury was substantially occasioned by her use of illegal drugs. The burden then shifted to the claimant to prove by a preponderance of the evidence that the illegal drugs did not substantially occasion her injury or accident.

When considering whether the claimant could rebut the presumption, the Court of Appeals noted that "'substantially occasioned' means there must be a direct, causal link between the use of illegal drugs and the injury or accident." Additionally, "the acts leading to the injury must require judgment, and that judgment must be poor or impaired." The Court of Appeals held that the claimant's decision to reach underneath the guard into a dangerous cutting machine was poor judgment, regardless of any alleged lack of training or instructions. Consequently, the claimant could not rebut the presumption and was not entitled to benefits.

Blair v. Am. Stitchco, Inc., 593 S.W.3d 44 (Ark. App. 2020).

In another marijuana use case, the claimant sustained an injury to his right thumb and index finger and the employer raised a drug defense to compensability. The claimant's job required him to strap large conveyor belt parts to a crane, balance the parts to prevent them from swaying, and then use a remote control to operate the crane and lift the parts. During one shift, the claimant could not properly balance the conveyor parts and used his body to prevent the parts from swinging. He then activated the remote control to lower the crane and conveyor parts but lowered the parts too quickly and they struck the remote control he was holding, injuring his right thumb and index finger.

After his injury, claimant was taken to the hospital, and over his objections, was administered a post-accident drug test which was positive for marijuana and opiates. Similar to *Blair*, this positive test triggered the rebuttable presumption that claimant's injury was substantially occasioned by the use of the illegal drugs and the burden shifted to claimant to overcome the presumption.

During the hearing, multiple witnesses testified both for and against the claimant and the claimant denied using marijuana the day of the accident. Several co-workers testified that claimant did not appear intoxicated on the date of the accident, while others testified that claimant had bloodshot eyes and that claimant's injury only could have occurred if he did something wrong, was not paying attention, or used poor judgment. Additionally, several witnesses confirmed that claimant had asked the hospital staff not to perform the drug test the day of his accident, although claimant denied this allegation.

Ultimately, the case turned on Claimant's credibility and the Commission held his testimony was not credible. Rather, the Commission found the witnesses who testified claimant's injury was due to extreme carelessness more credible. Consequently, because the Court of Appeals would not reweigh the Commission's credibility determinations, it upheld the Commission's denial of his claim.

Allen v. Employbridge Holding Co., 594 S.W.3d 165 (Ark. App. 2020).

Q. *Is medical-opinion testimony required to establish a causal connection between an alleged injury and a work-related accident?*

A. Not necessarily, but it is helpful. In *Bledsoe*, the claimant worked at a hotdog casing manufacturer, manually moving hotdog casings onto reels, when a reel weighing about thirty pounds fell and struck her chest and left forearm. This caused a hairline fracture to her sternum. The claimant also alleged this caused an injury to her neck. The claimant received medical treatment and did not make any neck complaints until two weeks after her work injury. After multiple examinations by an orthopedic specialist for her sternum injury, the specialist opined that the claimant's neck complaints were not related to the work accident. Additionally, the claimant was also evaluated by a neurosurgeon who initially opined that claimant's neck complaints were related to the accident. However, during his deposition, the neurosurgeon gave contradictory statements—he admitted he could not identify whether the neck problems were degenerative or related to trauma but still stated they were caused by the work accident. The claimant testified she did not have neck problems prior to the work accident.

On appeal, the Court of Appeals acknowledged "that medical-opinion testimony is not essential to establish the causal relationship between the injury and a work-related accident." The court then confirmed that if a medical opinion is put forth in an attempt to establish causation, that the medical opinion must be stated within a reasonable degree of medical certainty. In this case, the orthopedic specialist's opinion was stated within a reasonable degree of medical certainty, while the conflicting statements given by the neurosurgeon demonstrated his opinion was not stated within a reasonable degree of medical certainty. As such, the claimant's alleged neck injury was held to not be related to the work accident.

Bledsoe v. Viskase Companies, Inc., 593 S.W.3d 512 (Ark. App. 2020)

Q. *Does the Uniform Contribution Among Tortfeasors Act allow for the apportionment of fault to an employer, who is not a party to the action, and who is otherwise immune from liability?*

A. No. The claimant in *Hodge* sustained a compensable amputation injury to his leg after his leg was struck by an auger in a hopper/fertilizer blender while he was trying to dislodge clumps of fertilizer in the blender. The claimant received workers' compensation benefits for his injury and filed a products liability action against the manufacturer of the hopper. In the manufacturer's amended answer, it asserted that fault should be allocated according to the Uniform Contribution Among Tortfeasors Act (UCATA) between it and the employer. In doing so, the manufacturer was not seeking to recover from the employer, only to reduce its own liability in proportion to its percentage of fault. The claimant filed a motion to strike the amended answer and asserted that the manufacturer's fault could not be apportioned with a nonparty who was immune from liability. The circuit court agreed with the claimant and struck the amended answer because the exclusive remedy provision of the workers' compensation act prohibited the employer from being referenced or made a party to the action.

On appeal, the Court of Appeals stated that the Civil Justice Reform Act confirms that individual "defendants" are liable "only for the amount of damages allocated to that defendant in direct proportion to that defendant's percentage of fault." However, it recognized that the Civil Justice Reform Act did not provide any guidance on apportioning fault to nonparties. Therefore, the Court of Appeals turned to the UCATA, which allows contribution among "joint tortfeasors." This term is defined by the UCATA as ""two (2) or more persons or entities who may have *joint liability or several liability in tort* for the same injury to person or property, whether or not judgment has been recovered against all or some of them." (emphasis in original). The court held that because the employer was immune from tort liability due to the exclusivity provision in the Workers' Compensation Act, that it could not be considered a "joint tortfeasor" within the UCATA. Consequently, the court held that the employer's potential fault could not be considered, and the manufacturer's liability could not be reduced by any potential fault of the employer.

Indus. Iron Works, Inc. v. Hodge, 595 S.W.3d 9 (Ark. App. 2020).

Q. ***Is a claimant automatically entitled to wage-loss disability after he or she sustains a compensable injury to the body as a whole?***

A. No, but the Judge or Commission may award wage-loss disability in their discretion. The claimant in *Jaynes* was fifty-five when he was injured, and the Commission determined he sustained 11% impairment to his body as a whole. Prior to his injury, he had worked as an electrician for approximately thirty-four years. In addition to claimant's permanent partial impairment, the Commission awarded 10% wage-loss disability, as allowed by Ark. Code Ann. § 11-9-552(b)(1), which states as follows:

> In considering claims for permanent partial disability benefits in excess of the employee's percentage of permanent physical impairment, the Workers' Compensation Commission may take into account, in addition to the percentage of permanent physical impairment, such factors as the employee's age, education, work experience, and other matters reasonably expected to affect his or her future earning capacity.

In coming to its conclusion regarding wage-loss, the Commission considered the claimant's age, limited education, lack of transferrable skills, motivation, and work history over the past twenty years. The Court of Appeals also stated that other factors which could have been considered included claimant's medical evidence, postinjury income, credibility, and demeanor. Ultimately, the Court of Appeals upheld the Commission's additional 10% wage-loss disability as being supported by substantial evidence.

Tempworks Mgmt. Servs., Inc. v. Jaynes, 593 S.W.3d 519 (Ark. App. 2020).

In another illustrative case, the Court of Appeals confirmed that a claimant who sustained a low back injury and was therefore at least partially prevented from returning to work in the employer's maintenance department sustained a 10% wage-loss disability. The claimant in this case was working on bleachers which retracted into a wall above a concrete floor, when the bleachers released, causing him to fall

approximately eight to ten feet to the floor. This resulted in an injury to Claimant's lower back and left shoulder, and he was assessed permanent restrictions following his recovery.

The Commission evaluated Claimant's advanced age, limited education, prior work history consisting of physically demanding employment and related skills, and his permanent restrictions. Following its evaluation, the Commission decided Claimant was entitled to a 10% wage-loss disability. On appeal, the Court of Appeals, viewing the evidence in the light most favorable to the Commission's award, affirmed the award of wage-loss disability.

Hot Springs Convention Ctr. v. Phelps, ___S.W.3d___, 2021 Ark. App. 83 (2021).

Q. *Is a claimant required to present objective medical evidence to establish a causal relationship between his or her injury and the work-related accident?*

A. No. In *Brown*, the Court of Appeals reiterated a subtle but important distinction between the standard of proof for establishing whether an injury has occurred and whether that established injury was caused by the work-related accident. In doing so, the Court explained "that objective medical evidence is necessary to establish the existence and extent of an injury but not essential to establish the causal relationship between the injury and a work-related accident." The Court then quoted a prior Supreme Court ruling which stated:

> The plethora of possible causes for work-related injuries includes many that can be established by common-sense observation and deduction. To require medical proof of causation in every case appears out of line with the general policy of economy and efficiency contained within the workers' compensation law. To be sure, there will be circumstances where medical evidence will be necessary to establish that a particular injury resulted from a work-related incident but not in every case.

This distinction was important in the *Brown* decision, as there were two entirely different versions of the accident presented. The claimant was undeniably involved in a motor vehicle accident, but the issue was how the accident occurred. The claimant testified he was stopped at a red light and was rear-ended by a driver behind him traveling at least thirty miles per hour. However, the other driver issued an affidavit stating that she was completely stopped, and the claimant suddenly backed his work van into her car. Regardless of which version of events was true, it was established by objective medical evidence that claimant had injuries to his neck and left shoulder.

The question then became which version of the accident occurred, and whether that version caused the claimant's neck and left shoulder injuries. The Commission recognized that one of the two drivers had to be lying about the accident, but because the other driver did not testify and only presented an affidavit, it was insufficient to rebut claimant's testimony. The Commission therefore accepted the claimant's version of the accident. Under Claimant's version, the Commission noted that Claimant had presented medical evidence that the accident had caused his left shoulder and neck injuries. As such, the Commission held the injuries were compensable. Under the Court of Appeals' standard of review, which viewed the

evidence in the light most favorable to the Commission's decision, it affirmed the ruling.

Sears Roebuck & Co. v. Brown, 594 S.W.3d 896 (Ark. App. 2020).

The distinction between the standard of proof for establishing whether an injury has occurred and whether that established injury was caused by the work-related accident can be further understood by examining *Marshall v. Arkansas Department of Corrections*. In *Marshall*, the claimant failed to present objective medical evidence which was sufficient to prove she sustained the alleged injuries to her hip, thigh, knee, shoulder, arm, and head. Claimant testified that she fell at work, hit her head on a brick wall, and landed on concrete. She alleged that due to this accident she sustained multiple injuries and consequently had to walk with a cane.

On the day of her injury, Claimant was seen by a doctor and reported that she had pain from her right knee to her right hip but that she did not hit her head in the fall. The doctor further noted that the hip and knee pain was not significant. Then two weeks later, the claimant told her rheumatologist that while she fell at work, she did not sustain any significant injury. Claimant had previously treated with the rheumatologist just two weeks before the accident for chronic back and lower extremity pain and at that time, the rheumatologist was suspicious that she had significant osteoarthritis. Claimant was then seen by another physician who Claimant had also treated with for more than a year prior to the accident. The physician's prior notes confirmed Claimant had been using a cane for more than a year prior to the accident. Claimant also admitted to receiving treatment to her right hip, thigh, knee, and low back prior to her fall.

The Judge therefore held, and both the Commission and Court of Appeals affirmed, that Claimant did not present sufficient objective medical evidence showing that she sustained any injuries which could have been due to the alleged work accident.

Marshall v. Arkansas Dep't of Correction, 594 S.W.3d 160 (Ark. App. 2020).

Conversely, the Court of Appeals reversed the Commission in *Melius v. Chapel Ridge Nursing Center, LLC* and found the claimant did prove she sustained a compensable injury to her right buttock and thigh with objective medical findings. The claimant initially reported a work injury after she helped lift a patient being transferred to the emergency room and alleged she injured her right buttock and thigh. Claimant complained that this resulted in muscle spasms in her injured buttock and right thigh and received conservative treatment including therapy and injections. Although her treatment lasted several months, no doctor or physical therapist witnessed any evidence of muscle spasms during that time.

After a hearing, the Administrative Law Judge denied Claimant sustained a compensable injury because she failed to provide objective medical findings to support that her alleged muscle spasms were caused by the work accident. This finding was affirmed by the Commission. However, the Court of Appeals reversed. In rendering its decision, the Court of Appeals held it was significant that Claimant was diagnosed with a strain of the muscle, fascia, and tendons of the right hip and that she received conservative treatment for this condition. The Court held this was objective

medical evidence sufficient to carry Claimant's burden of proof. Further, the Court held that there was no requirement that a doctor or therapist actually witness Claimant's muscle spasms in order for the spasms to be considered a compensable injury. As such, the Court of Appeals reversed and held Claimant carried her burden of proving she sustained a compensable injury which was established by objective medical evidence.

Melius v. Chapel Ridge Nursing Ctr., LLC, ___S.W.3d___ (Ark. App. 2021).

Q. *Are idiopathic injuries compensable under the Act?*

A. No. The sixty-two-year-old claimant in this matter alleged that he sustained a compensable gastrointestinal injury, which then led to additional injuries to his head and knee. Claimant worked as a stocker and over the course of two days he was required to move pallets of water, which he testified were "unusually heavy" and then move fifty to fifty-five-pound bags of dog food. After Claimant finished work the second day, he noticed several instances of having blood in his stool. Claimant then attempted to report a work-related injury the next day, but while he was filling out the paperwork, he felt the urge to use the restroom and while in the restroom, he again passed blood and fainted. After he fainted, he fell and struck his head and his right knee. The injury to Claimant's head required stitches and fluid had to be drained from his knee. After receiving treatment, Claimant was eventually diagnosed with gastrointestinal bleeding. The Judge and Commission both held Claimant failed to prove he sustained a compensable injury due to lifting at work and determined that his injuries were idiopathic in nature.

As explained by the Court of Appeals, an idiopathic injury "is one whose cause is personal in nature, or peculiar to the individual." These are distinguishable from work injuries due to an unexplained cause, which are generally compensable, because idiopathic injuries are not related to the particular claimant's employment. In considering Claimant's injury, the Court of Appeals reiterated that "an injury is 'accidental' only if it is caused by a specific incident and is identifiable by time and place of occurrence." The court further found it was significant that Claimant could not "point to a time, a place, or an occurrence" of his injury and that his initial onset of bleeding occurred at home. Additionally, it determined that the ultimate cause of Claimant's gastrointestinal bleeding was not identifiable. Consequently, the Court of Appeals held that Claimant failed to establish a compensable injury with objective medical evidence findings. The court therefore also held that Claimant's head and knee injury were similarly not compensable because they were due to a syncopal event which was caused by the idiopathic gastrointestinal bleeding injury.

Nolen v. Walmart Assocs., ___S.W.3d___, 2021 Ark. App. 68 (2021)

Q. *If a claimant is given temporary restrictions and refuses to return to work within those restrictions, but is later given additional restrictions which cannot be accommodated, is the claimant entitled to temporary total disability benefits?*

A. Not during the period of the refusal, but potentially after the additional restrictions which cannot be accommodated are placed. In this case, the claimant worked as an over the road truck driver and sustained a compensable injury to his left

knee on October 5, 2017. On October 9, 2017, the claimant was given temporary restrictions which the employer could accommodate. Claimant admitted that he was given temporary restrictions, that the employer offered him work within those restrictions, and that he refused to return to work within those restrictions.

However, Claimant was then diagnosed with a deep vein thrombosis (DVT) which was caused by his left knee injury, on October 16, 2017. The doctor who had initially assessed his restrictions advised him to follow-up with his primary care physician to treat the DVT. The claimant eventually saw his primary care physician on November 16 and 20, 2017, who provided treatment for the DVT. His primary care physician then issued updated restrictions on December 21, 2017 which took the claimant completely off work.

When examining the above periods—from October 9, 2017 to December 20, 2017 and from December 21, 2017 into the future—the Court of Appeals came to different conclusions regarding Claimant's entitlement to temporary total disability benefits. As Claimant admitted that he refused to return to work within his temporary restrictions from October 9, 2017 to December 20, 2017, the Court of Appeals confirmed it was proper to deny the claimant temporary total disability benefits during this period pursuant to Ark. Code Ann. § 11-9-526. However, it held that from December 21, 2017 into the future, Claimant's prior refusal of accommodated work was irrelevant. The Court of Appeals held that because claimant's primary care physician took him entirely off work, that there was no accommodated work which could have been provided. Therefore, Claimant was entitled to temporary total disability until either his healing period ended, or he returned to work.

Grant v. Westar Refrigerated Transportation, 594 S.W.3d 154 (Ark. App. 2020).

Q. ***If a Claimant sustains a compensable injury, is given restrictions for seven days, and then refuses to return to work within those restrictions, is he entitled to temporary total disability benefits for the time he is off work?***

A. No. The claimant in *Potter v. Kelly Services, Inc.* sustained a compensable injury to his back on May 31, 2018 while working for a temporary agency. Claimant was then sent to a doctor on June 4, 2018 and was given temporary restrictions which were to last for seven days. He was also advised to return to the doctor's office on June 11, 2018. At some point during the seven-day period, Claimant was offered an accommodated position, but instead of returning to work, he abandoned his position and went to work for several different temporary agencies performing full duty work. Then on March 11, 2019, Claimant was taken off work by a doctor at the Veterans' Affairs hospital and therefore claimed he was also entitled to temporary total disability benefits from March 11, 2019 to a date to be determined.

Both the Judge and the Commission denied that Claimant was entitled to temporary total disability benefits either during the initial seven-day period or after March 11, 2019. They held in part that Claimant failed to sustain his burden of proving him being taken off work as of March 11, 2019 was due to his initial work injury.

On appeal, the Court of Appeals affirmed both the Judge and the Commission. The Court specifically noted that under Ark. Code Ann. § 11-9-501, Claimant was not

entitled to temporary total disability benefits during the first seven days of disability. Additionally, the employer had offered accommodated work during that period, which Claimant refused. As such, he was not entitled to any temporary total disability benefits during the first seven days following his accident. Additionally, due to his refusal to return to work for employer, he was similarly barred from receiving temporary total disability benefits under Ark. Code Ann. § 11-9-526. The Court of Appeals also affirmed the Commission's decision that Claimant failed to sustain his burden of proving that the restrictions placed on March 11, 2019 were due to his original accident. This therefore differentiated the claimant's condition in *Potter* from the claimant's injuries in *Grant* discussed above.

Potter v. Kelly Servs., Inc., 610 S.W.3d 670 (Ark. App. 2020).

Q. *Does paying workers' compensation insurance premiums for a particular individual prevent a finding that the individual in question is an independent contractor rather than an employee?*

A. Not necessarily, depending on the facts of the case. Whether an employer paid a workers' compensation insurance premium for a particular individual is one factor to consider when deciding whether the individual is an independent contractor or an employee. According to the Court of Appeals, other factors include:

(a) the extent of control which, by the agreement, the master may exercise over the details of the work;
(b) whether or not the one employed is engaged in a distinct occupation or business;
(c) the kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of the employer or by a specialist without supervision;
(d) the skill required in the particular occupation;
(e) whether the employer or the workman supplies the instrumentalities, tools, and the place of work for the person doing the work;
(f) the length of time for which the person is employed;
(g) the method of payment, whether by the time or by the job;
(h) whether the work is a part of the regular business of the employer;
(i) whether the parties believe they are creating the relation of master and servant; and
(j) whether the principal is in the same business as the alleged independent contractor.

In this case, the claimant provided in-home physical therapy services for the company and had to travel to the patient's homes to provide treatment. He was injured in a motor vehicle accident and suffered a brain injury.

When considering Claimant's case, the Court of Appeals advised that "an independent contractor is 'one who contracts to do a job according to his or her own method and without being subject to the control of the other party, except as to the result of the work.'" It then examined the Commission's application of the above factors. For example, the company provided claimant with some equipment, paid him on a per-

patient basis, had some direction over claimant's scheduling, and provided reminders about when certain forms had to be submitted. The claimant determined the order in which he saw his patients, could work for other entities if he chose, and had control over the patients' plan of care. Additionally, Claimant signed an affidavit acknowledging he was an independent contractor for workers' compensation purposes. However, after Claimant signed the affidavit, the company was required to begin paying workers' compensation insurance premiums for the therapists, based upon the wages paid to the therapists.

Although the Court of Appeals recognized the various policy arguments made by Claimant's attorney, it ultimately held that the claimant was an independent contractor based on the particular facts of the case. It also held that the company was not estopped from arguing that Claimant was an independent contractor by virtue of paying workers' compensation insurance premiums. It further held that the payment of premiums did not constitute a waiver of the company's argument that Claimant was an independent contractor.

Davis v. Ed Hickman, P.A., 598 S.W.3d 70 (Ark. App. 2020).

Q. ***After a claimant is determined to have a compensable injury, what medical treatment is an employer required to provide?***

A. The employer must provide the claimant with "such medical and surgical treatment 'as may be reasonably necessary in connection with the injury received by the employee.'" Under the Act, the employer takes the claimant as it finds him or her, and therefore if the claimant's accident either caused a new injury or aggravated a non-compensable preexisting condition, he or she is entitled to reasonable medical treatment. This may include necessary diagnostic testing, or care to reduce or alleviate claimant's symptoms, maintain a level of healing, or prevent further deterioration.

In this case, the Court of Appeals confirmed the claimant sustained a compensable injury to his neck. While treating, he underwent an MRI which was ordered by Dr. Berestnev and showed degenerative changes in his cervical spine. Dr. Berestnev opined that this condition was not work-related and referred the claimant to his primary care physician, Dr. McGowan, for additional treatment recommendations. The MRI was also reviewed by a Dr. Hronas who opined it did not show any objective evidence of an acute injury. Prior to his work accident, Claimant had treated with Dr. McGowan for right shoulder pain radiating into his neck on at least one occasion. Dr. McGowan then referred Claimant to Dr. Armstrong, a neurosurgeon, who diagnosed Claimant with cervical stenosis of the spine, cervical spinal-cord compression, and degeneration of the cervical disc. Dr. Armstrong recommended a cervical fusion to treat these conditions. However, as noted by the Court of Appeals, Dr. Armstrong did not specifically opine that either that the fusion surgery was necessary due to the work injury or that the accident aggravated a preexisting condition which now required surgery.

After considering the various doctors' opinions, the Commission held that the cervical fusion recommended by Dr. Armstrong was reasonably necessary in connection with

Claimant's work-related injury. Additionally, it held that if Claimant had a preexisting condition, it was aggravated, accelerated, or combined with the work injury. However, on appeal, the Court of Appeals reversed and did not hold that the fusion surgery was reasonable and necessary treatment related to Claimant's work injury. Rather, the Court of Appeals remanded to the Commission to make specific factual findings as to what Claimant's preexisting condition was and whether the recommended spinal fusion surgery "was reasonably necessary to treat a condition caused or aggravated by the workplace injury."

USA Truck, Inc. v. Webster, 599 S.W.3d 368 (Ark. App. 2020).

After remand from the Court of Appeals, the Commission additionally remanded the matter to the Administrative Law Judge for the Judge to decide "whether [the] spinal surgery was reasonably necessary in connection with the compensable injury to the claimant's cervical spine." It is unclear what the Administrative Law Judge's ultimate determination was, or whether the issue was further litigated in front of the Judge.

Webster v. USA Truck, Inc., No. G805756, 2020 WL 4584066 (Ark. Work. Comp. Com. July 9, 2020).

Q. *Whether an insurance carrier can be required to pay Claimant's attorney's fees in a subrogation action if the carrier seeks to enforce its subrogation lien on Claimant's third-party recovery?*

A. Yes, if Claimant was not "made whole" by his or her recovery in the third-party suit and the carrier refused to release its subrogation lien. In this case, Claimant was injured when a piece of steel from a crane fell on him. The workers' compensation insurance carrier then paid more than $114,000.00 in medical and indemnity benefits. Following the workers' compensation claim, Claimant filed a third-party claim against several defendants and the insurance carrier moved to intervene in the suit, asserting its subrogation interest on any recovery from the third-party defendants. Claimant then settled with the third-party defendants and sent the agreement to the insurance carrier, stating that he had not been "made whole" by the settlement and requesting that the carrier release its lien. The carrier refused to release the lien, and therefore Claimant filed a motion to void the lien and the carrier filed a motion for a "made whole" hearing.

Following the "made whole" hearing, the circuit court held Claimant was not made whole and dismissed the carrier from the claim with prejudice. Claimant's attorney then filed for attorney's fees from the carrier under Ark. Code Ann. § 11-9-715(a)(2)(B), which states:

> (i) In all other cases whenever the Commission finds that a claim has been controverted, in whole or in part, the Commission shall direct that fees for legal services be paid to the attorney for the claimant as follows: One-half (1/2) by the employer or carrier in addition to compensation awarded; and one-half (1/2) by the injured employee or dependents of a deceased employee out of compensation payable to them.
>
> (ii) The fees shall be allowed only on the amount of compensation for indemnity benefits controverted and awarded.

The issue then became whether the carrier's filing of a subrogation lien and refusing to release it after Claimant settled with the third-party defendants constituted the carrier controverting the claim. The circuit court held that the carrier had controverted the claim and that Claimant's attorney was entitled to recover fees based on the approximate $31,000 paid in indemnity benefits.

On appeal, the Court of Appeals affirmed the circuit court and held that Claimant's attorney was entitled to recover attorney's fees. The court held that it was immaterial that the subrogation claim proceeded in front of the circuit court, rather than the Commission. The court explained that because the carrier refused to withdraw its subrogation lien, Claimant's attorney had to incur fees to litigate the matter at the "made whole" hearing, and therefore the circuit court had the authority to award fees. Additionally, the Court of Appeals was not persuaded by the carrier's argument that asserting a subrogation lien did not amount to the controversion of a claim. The court held that if a claimant must incur legal expenses to defend his or her disability benefits award, that constitutes direct proof of controversion. As such, because Claimant had to incur legal expenses during the "made whole" hearing, and the circuit court determined he was not made whole and therefore the carrier's right to subrogation did not accrue, the carrier had in effect controverted the claim and was required to pay Claimant attorney's fees.

Liberty Mut. Ins. Co. v. Youngblood, 609 S.W.3d 468 (Ark. App. 2020).

Q. If a claimant is injured due to the actions of a co-employee, can the injured claimant sue the co-employee in a civil negligence action?

A. Generally, no. In this case, Claimant's co-employee was driving a truck and Claimant was the passenger, when the employees were involved in a motor vehicle accident that left Claimant paralyzed. Claimant's employer accepted the workers' compensation claim and Claimant filed a suit against his co-employee alleging his negligence caused the accident. The co-employee asserted that he was immune from suit due to the exclusive remedy provision of the Workers' Compensation Act.

The Court of Appeals confirmed that an employer's immunity from suit was previously extended "to co-employees for actions arising from the alleged failure to provide a safe workplace because those employees are charged with the employer's nondelegable duty of providing a safe workplace." As such, any alleged negligence of a co-employee which fell within this description was non-actionable in a civil suit, and the claimant's exclusive remedy was within the Workers' Compensation Act. The Court of Appeals also held that co-employee immunity still applied even when the employer accepted the claim as compensable and paid all of Claimant's medical and indemnity benefits. Claimant also attempted to make other arguments to the Court of Appeals, but the court refused to hear them because they were not properly preserved for review.

Moore v. Bestway Rent to Own, ___S.W.3d___, 2021 Ark. App. 41 (2021).

Q. ***If a Claimant alleges hearing loss due to a work accident, is the audiologist always required to adjust the hearing tests for presbycusis, or degenerative changes in the ear caused by aging, in determining hearing loss?***

A. No. The Court of Appeals stated that occupational hearing loss must be established by medical evidence supported by objective findings and that Ark. Code Ann. § 11-9-102(16)(A)(iii) sets out the requirements for establishing the objective evidence in occupational hearing loss cases. In such cases, audiological tests that measure air and bone conduction thresholds and speech discrimination ability, among other medically recognized and accepted testing may be used. Additionally, the statute requires that, "[a]ny difference in the baseline hearing levels must be confirmed with a subsequent test within the next four (4) weeks but not before five (5) days and being adjusted for presbycusis." However, the Court of Appeals held that adjustment for presbycusis is not required in all cases.

In this case, Claimant was a deputy sheriff who responded to a family member's house because another member of the family had locked himself in a shed and was acting strangely. Unfortunately, as Claimant approached the shed, it exploded and caused Claimant to be thrown several feet. This resulted in injuries to his forearm and shoulder, which were accepted, and allegedly resulted in bilateral hearing loss and tinnitus. Claimant admitted that prior to the explosion, he had experienced intermittent, bilateral tinnitus every three to four months but stated that it always went away. However, he denied any hearing loss before the explosion. He also alleged that his tinnitus had become worse in his right ear after the explosion.

Claimant was therefore administered several hearing tests. Both the initial testing and the follow-up testing performed three weeks later confirmed he sustained some level of hearing loss from the normal parameters. However, neither test was adjusted for presbycusis. The employer therefore argued that Claimant failed to meet his burden of proving that he sustained hearing loss because the tests did not account for any pre-injury hearing loss due to the natural aging process. The employer also argued that if the Court of Appeals did not require that the tests be adjusted for presbycusis, that it would allow Claimant to have a compensable claim without meeting the statutory requirements and thus would improperly shift the burden of proof to the employer.

On appeal, the Court of Appeals overruled both of the employer's arguments. It held that because there was no evidence that Claimant had any pre-injury hearing loss, that the audiology tests did not need to be adjusted for presbycusis. It further held that because the audiology tests showed that Claimant sustained some hearing loss, that this met his burden of proof with objective medical evidence. Consequently, the burden was not improperly shifted to the employer and the Court of Appeals affirmed that Claimant was entitled to compensation for his permanent binaural hearing loss.

Craighead Cty. v. Tipton, ___S.W.3d___, 2020 Ark. App. 416 (2020).

Q. ***Is it possible for a claimant to sustain a work-related injury, but not be entitled to an award of permanent partial impairment for that injury?***

A. Yes. As explained by the Court of Appeals, "[p]ermanent impairment is permanent functional or anatomical loss remaining after the healing period has ended." The existence, and the extent of, any impairment must be "supported by objective and measurable physical or mental findings." However, range of motion testing cannot be used to support an impairment rating when examining spinal injuries.

In this case, Claimant had a significant prior neck and back injury, which required fusion surgeries in both her cervical and lumbar spine. After Claimant was released from these surgeries, she continued to have symptoms in both her back and her neck. Then over a year after her surgeries, Claimant sustained an additional injury to her lumbar spine while climbing a ladder at work. She also alleged that she sustained an additional injury to her neck in this accident, but the Commission and Court of Appeals both held Claimant failed to sustain her burden of proving her neck injury with objective medical evidence. Claimant was examined the same day as her injury and the doctor noted that she had muscle spasms and nerve impingement in her low back. Claimant then underwent a CT scan which did not show any acute findings and confirmed her lumbar hardware was stable. She was also examined by a neurosurgeon who opined Claimant did not show any signs of lumbar radiculopathy. The neurosurgeon further opined Claimant had reached maximum medical improvement for her back injury and did not sustain any impairment. The Judge and Commission both adopted this finding.

The Court of Appeals ultimately affirmed the Commission's determination that Claimant did not sustain any impairment. In reaching its decision, the court recognized that Claimant had evidence of muscle spasms and nerve impingement, which were objective lumbar findings. However, it held it was significant that Claimant had a preexisting lumbar spine injury which she was still actively treating for near the time of the second work accident. Additionally, no doctor issued an impairment rating for Claimant. The Court of Appeals therefore held Claimant did not sustain any impairment to her lumbar spine although she had a compensable injury.

Willis v. Arkansas Dep't of Correction, ___S.W.3d___, 2021 Ark. App. 50 (2021).

Q. ***Is active range of motion testing considered objective and measurable evidence that can be used to support an award of permanent partial impairment?***

A. No. As discussed above, functional impairment "must be supported by objective and measurable evidence." Evidence is only considered objective when it "cannot come under the claimant's voluntary control." Consequently, because active range of motion testing is entirely within the claimant's control, it is considered subjective in nature. Alternatively, passive range of motion testing is considered objective because it is performed by the physician, rather than the claimant.

The Court of Appeals applied the above principles to a claimant's alleged hand injury and resulting impairment. The employer admitted that Claimant sustained an injury to his thumb when his left palm was struck by a handle of a safety latch. An MRI performed on Claimant's hand after the injury showed "a small, nondisplaced acute fracture at the base of the proximal phalanx of the thumb at the ulnar collateral

ligament insertion" as well as degenerative changes. However, Claimant alleged that he sustained an injury to his whole hand, which should have been treated as an injury to the body as a whole.

Due to his injury, Claimant received conservative treatment including casting and physical therapy. During treatment, Claimant presented exaggerated symptoms to his doctors and his physical therapist noted that Claimant demonstrated greater range of motion in his thumb when he was unaware he was being observed versus when the therapist was providing treatment. In addition to these discrepancies, the Judge was presented with two impairment ratings. One doctor opined Claimant sustained 35% impairment to the left hand based on active range of motion testing. While the other doctor opined Claimant sustained 0% impairment as Claimant's injury was only a mild sprain and non-displaced fracture and explained that the range of motion deficits were due to Claimant's pre-existing arthritis. When considering these two impairment ratings, the Judge assessed very little weight to the 35% impairment rating because it based on active range of motion testing, the motion deficits were due to Claimant's preexisting arthritis, and the rating was not limited to Claimant's thumb. As such, the Judge ruled there was no objective evidence that Claimant sustained any injury to his hand, outside of the thumb injury, or that he had any impairment. This opinion was adopted by the Commission, and ultimately, the Court of Appeals was persuaded by this logic and therefore affirmed the Judge's denial of impairment.

Evans v. Firestone Bldg. Prod., Ltd., 594 S.W.3d 139 (Ark. App. 2020).

Q. ***May the Commission properly consider the opinion of a nurse practitioner in determining whether a claimant sustained a compensable injury?***

A. Yes. As the Court of Appeals explained, the Commission "has the authority to determine the medical soundness and probative force of medical opinion." The court confirmed that the report of a nurse practitioner is such a medical opinion which the Commission could consider, "and assign it whatever probative value it chooses."

In *Allen*, the claimant attempted to lift a battery weighing over one-hundred pounds and injured his back. The employer admitted Claimant sustained a back strain but denied that he sustained a more significant injury. In support of this contention, the employer noted that according to the physical therapy notes, Claimant's pain had returned to a 0/10 within a month after the initial injury. The employer also argued that it was not until approximately two and a half months after his injury that Claimant alleged severe pain in his back. After the severe pain began, Claimant was examined by an orthopedic doctor who eventually performed back surgery.

Among other issues on appeal, the employer argued that the Commission erred by considering a nurse practitioner's note as evidence that Claimant did not sustain an additional injury. The nurse's note showed that Claimant advised the nurse that he did not believe he sustained an additional injury, and that him lifting the one-hundred-pound battery was the last thing he remembered doing that injured his back. The Court of Appeals held that because this medical evidence was properly submitted to the Commission, that it was proper for the Commission to consider it. Consequently, it

affirmed the Commission's determination that Claimant sustained a compensable injury and was therefore entitled to medical and disability benefits.

Searcy Sch. Dist. v. Allen, 594 S.W.3d 169 (Ark. App. 2020).

Q. ***Whether a letter filed with the Commission formally constitute a claim for additional medical benefits that can toll the statute of limitations?***

A. No. The Claimant, Menser, a forty-year-old at the time of injuries, was employed as a patrol deputy for the White County Sheriff's Department. On December 13, 2013, Claimant began to experience a severe headache and numbness while driving the patrol car. Emergency personnel arrived to treat Claimant and noted, "Patient has a strong smell of rotten eggs on his clothes and noticeable smell around the vehicle." Claimant was then treated for possible carbon monoxide poisoning and was released.

Claimant's symptoms worsened the next day, and he returned to the hospital. Claimant was diagnosed with chemical pneumonitis and was treated with intravenous steroids and updrafts.

Upon discharge from the hospital, Claimant went to the sheriff's department to gather his belongings. Claimant inspected his vehicle and noticed a white residue in the wheel area and on a new battery that had recently been installed. Claimant saw scorch marks and believed the battery had at one point been on fire. Claimant saw a white residue and the battery's contents on the floor of the truck.

On December 20, 2013, Claimant completed a Form AR-1 (First Report of Injury or Illness) and AR-2 (Employer's Intent to Accept or Controvert Claim). Claimant never filed a Form AR-C to request compensation because appellants listed the claim as compensable on the AR-2 and already began making payments.

The last medical benefit was paid on March 26, 2014, and the last indemnity benefit was paid on April 21, 2014. These payments totaled $25,136.45 in medical and indemnity benefits.

On July 11, 2014, Claimant's attorney submitted a letter requesting a hearing on medical benefits. On July 5, 2017, the ALJ entered an opinion finding, *inter alia*, that Claimant sustained compensable brain and neuropathy injuries and that the statute of limitations did not bar the claim because it had been tolled by the letter from Claimant's attorney. Appellants appealed to the Commission.

On November 3, 2017, the Commission filed its opinion affirming and adopting the ALJ's decision. The Commission found that Claimant never filed a Form AR-C, but that Claimant's counsel had filed a letter with the Commission on July 11, 2014. The Commission stated the letter sufficiently constituted a claim for additional medical benefits within the requisite two-year statutory period.

The Employer and Insurer appealed arguing that Claimant's claim for additional benefits is barred by the statute of limitations because Claimant's attorney never formally requested additional benefits. The Court of Appeals affirmed the Commission's award. The Supreme Court of Arkansas reversed that decision on the grounds that Claimant's letter to Commission, requesting a hearing on medical benefits and temporary total disability, did not formally constitute a claim for additional

medical benefits that could toll the statute of limitations on claims for additional compensation.

White County J. v. Menser, 597 S.W.3d 640 (Ark. 2020)

Notes Pages

Notes Pages

Notes Pages

ILLINOIS WORKERS' COMPENSATION

I. Jurisdiction - Illinois jurisdiction is appropriate when:

A. If the petitioner is injured in Illinois, even if the contract for hire is made outside of Illinois.

B. The petitioner's employment is principally localized within Illinois, regardless of the place of accident or the place where the contract for hire was made.

C. If the last act necessary to complete the contract for hire was made in Illinois.

II. Compensability Standard

A. Accident or accidental injury must arise out of and in the course of employment.
   1. Accident arises out of the employment when there is a causal connection between the employment and the injury.
   2. Injury must be traceable to a definite time, place, and cause.

B. *Medical Causation*: The petitioner must show that the condition or injury might or could have been caused, aggravated, or accelerated by the employment.

III. Employee must provide notice of the accident.

A. The petitioner must give notice to the employer as soon as practicable, but not later than 45 days after the accident.

B. Defects/Inaccuracy in the notice is no defense unless the employer can show it was unduly prejudiced.
   - This is difficult to show in Illinois because the petitioner directs his/her own medical treatment.

IV. Accident Reports

A. Employer must file a report in writing of injuries which arise out of and in the course of employment resulting in the loss of more than three scheduled workdays.
   - This report must be filed between the 15th and 25th of each month.

B. For death cases, the employer shall notify the Commission within 2 days following the death.

C. These reports must be submitted on forms provided by the Commission.

V. Application Filing Periods - Statute of Limitations

A. Petitioner must file within three years after the date of accident, or two years after the last compensation payment, whichever is later.

B. In cases where injury is caused by exposure to radiological materials or asbestos, the application must be filed within 25 years after the last day that the petitioner was exposed to the condition.

VI. Average Weekly Wage (AWW)

A. General Rule: Divide the year's earnings (52 weeks) of the petitioner by the number of weeks worked during the year.
   1. *e.g.*, Sum of wages for 52 weeks prior to the accident = $40,000.
      - $40,000/52 = $769.23.

B. If petitioner lost five or more calendar days during a 52-week period prior to the accident, then divide the annual earnings by the number of weeks and portions of weeks the petitioner actually worked.
   1. e.g., Sum of wages for 52 weeks prior to the accident = $30,000 but petitioner missed 10 days = $30,000/50 = $600.00.

C. If petitioner worked less than 52 weeks with the employer prior to the injury, divide amount earned during employment by number of weeks worked.
   1. e.g., Petitioner worked 30 weeks and earned $20,000 during this time $20,000/30 = $666.66.

D. If due to shortness of the employment, or for any other reason it is impractical to compute the average weekly wage using the general rule, average weekly wage will be computed by taking the average weekly wage of a similar employee doing the same job.

E. Overtime—Overtime is excluded from AWW computation unless it is regular or mandatory.
   1. If overtime is regularly worked, it is factored into AWW but at straight time rate.
   2. Overtime is considered regularly worked on a case by case basis, but it has been determined that it is regular when:
      a. Claimant worked overtime in 40 out of 52 weeks
      b. Working more than 40 hours 60% of time
      c. Working overtime in 7 out of 11 weeks prior to an injury
   3. If overtime is infrequently worked but it is mandatory it must be considered in AWW computation.

F. When calculating a truck driver's AWW, the only funds to be considered are those that represent a "real economic gain" for the driver. *Swearingen v. Industrial Commission*, 699 N.E.2d 237, 240 (Ill. App. 5th Dist. 1998).
   1. Petitioner's gross earnings for the 52 weeks prior to the date of loss including all earnings made per mile are divided by 52 to determine the AWW. However, any monies that the driver uses to pay for taxes, fees, etc., are not included in the gross earnings, as they do not represent real economic gain.

VII. Benefits and Calculations

A. **Medical Treatment**—Pre-2011 Amendments: Petitioner chooses the health care provider, and the employer/insurer is liable for payment of:
   1. First Aid and emergency treatment.
   2. Medical and surgical services provided by a physician initially chosen by the petitioner or any subsequent provider of medical services on the chain of referrals from the initial service provider.
   3. Medical and surgical services provided by a second physician selected by the petitioner (2nd Chain of Referral).
   4. If employee still feels as if he needs to be treated by a different doctor other than the first two doctors selected by the petitioner (and referrals by these doctors), the employer selects the doctor.
   5. When injury results in amputation of an arm, hand, leg or foot, or loss of an eye or any natural teeth, employer must furnish a prosthetic and maintain it during life of the petitioner.
   6. If injury results in damage to denture, glasses or contact lenses, the employer shall replace or repair the damaged item.
   7. Furnishing of a prosthetic or repairing damage to dentures, glasses or contacts is not an admission of liability and is not deemed the payment of compensation.

B. **2011 Amendments** (In effect for injuries on or after September 1, 2011)
   1. Section 8(4) of the Act now allows employers to establish Preferred Provider Programs (PPP) consisting of medical providers approved by the Department of Insurance.
      - The PPP only applies in cases where the PPP was already approved and in place at the time of the injury. Petitioners must be notified of the program on a form promulgated by the Illinois Workers' Compensation Commission (IWCC).
   2. Under the PPP, petitioners have 2 choices of treatment providers from within the employer's network. If the Commission finds that the second choice of physician within the network has not provided adequate treatment, then the petitioner may choose a physician from outside the network.
   3. Petitioners may opt out of the PPP in writing, at any time, but this choice counts as one of the employee's two choices of physicians.

4. If a petitioner chooses non-emergency treatment prior to the report of an injury, that also constitutes one of the petitioner's two choices of physicians.

C. **Medical Fee Schedule**—Illinois Legislature created a Medical Fee Schedule that enumerates the maximum allowable payment for medical treatment and procedures.
   1. Maximum fee is the lesser of the health care provider's actual charges or the fee set for the schedule.
   2. The fee schedule sets fees at 90% of the 80th percentile of the actual charges within a geographic area based on zip code.
   3. The 2011 Amendments to Section 8.2(a) of the Act reduces all current fee schedules by 30% for all treatment performed after September 1, 2011.
   4. Out-of-state treatment shall be paid at the lesser rate of that state's medical fee schedule, or the fee schedule in effect for the Petitioner's residence.
   5. In the event that a bill does not contain sufficient information, the employer must inform the provider, in writing, the basis for the denial and describe the additional information needed within 30 days of receipt of the bill. Payment made more than 30 days after the required information is received is subject to a 1% monthly interest fee. (Prior to the Amendments, this fee accrued after 60 days, now it accrues after 30 days.)

D. **Temporary Total Disability (TTD)**
   1. 2/3 of AWW
   2. If temporary total disability lasts more than three (3) working days, weekly compensation shall be paid beginning on the 4th day of such temporary total incapacity. If the temporary total incapacity lasts for 14 days or more, compensation shall begin on the day after the accident.
   3. Minimum TTD rate is 2/3 (subject to 10% increase for each dependent) of Illinois minimum wage or Federal minimum wage, whichever is higher.
      - For the minimum and maximum rates for various dates.

E. **Temporary Partial Disability (TPD)**
   1. 2/3 of the difference between the average amount the petitioner is earning at the time of the accident and the average gross amount the employee is earning on the modified job.
   2. Normally applicable in light duty situations.

F. **Permanent Partial Disability (PPD)**
   1. 60% of AWW
   2. See rate card for value of body parts
   3. Minimum PPD rate is 2/3 (subject to 10% increase for each dependent) of Illinois minimum wage or Federal minimum wage, whichever is higher—as of 02/01/06 the Illinois minimum wage is higher ($6.50/hour).

G. **Person as a whole—Maximum of 500 weeks**

1. General rule if injury is not listed on rate card, it is a person as a whole injury.
2. Common for back injuries.

H. **Level of the hand for carpal tunnel claims = 190 weeks**

1. For claims arising after September 1, 2011, the 2011 Amendments return the maximum award for the loss of the use of a hand for carpal tunnel cases to the pre-2006 level of 190 weeks. The maximum award for the loss of the use of a hand in carpal tunnel cases was previously 205 weeks. For all hand injuries not involving carpal tunnel syndrome, the maximum award for the loss of the use of a hand remains at 205 weeks.

I. **Carpal Tunnel Syndrome**

1. The 2011 Amendments to Section 8(e)9 cap repetitive Carpal Tunnel Syndrome awards at 15% permanent partial disability of the hand, unless the Petitioner is able to prove greater disability by clear and convincing evidence.
2. If the petitioner is able to prove by clear and convincing evidence greater disability than 15% of the hand, then the award is capped at 30% loss of use of the hand.
3. The 2011 Amendments apply to injuries arising after September 1, 2011, and only apply to cases involving *repetitive* Carpal Tunnel Syndrome. The cap of 15% or 30% does not apply to cases involving Carpal Tunnel Syndrome brought on by an acute trauma.

J. **Disfigurement**

1. Usually scarring.
2. Must be to hand, head, face, neck, arm, leg (only below knee), or chest above the armpit line.
3. Maximum amount is 150 weeks if the accident occurred before 07/20/05 or between 11/16/05 and 01/31/06.
4. Maximum amount is 162 weeks if accident occurred between 07/20/05 and 11/15/05 or on or after 02/01/06.
5. Disfigurement rate is calculated at 60% of AWW.
6. A petitioner is entitled to *either* disfigurement or permanent partial disability for a specific body part, not both.

K. **Death**

1. Maximum that can be received can’t exceed the greater of $500,000 or 25 years of benefits.

L. **Permanent Total Disability**

1. Only arises when the petitioner is completely disabled which means the petitioner is permanently incapable of work.
2. Statutory PTD
    a. Statutory PTD arises when: loss of both hands, arms, feet, legs, or eyes.
    b. Employee receives weekly compensation rate for life, or a lump sum (based on life expectancy)
    c. PTD payments are adjustable annually at the same percentage increase as that which the state's average weekly wage increased, but this is capped at the maximum rate.
3. Odd-Lot PTD
    a. A petitioner who has disability that is limited in nature such that he or she is not obviously unemployable, or if there is no medical evidence to support a claim of total disability, the petitioner may fall into the odd-lot category of permanent total disability.
    b. The petitioner must establish the unavailability of employment to a person in his or her circumstances.
    c. The petitioner must show diligent but unsuccessful attempts to find work, or that by virtue of the petitioner's medical condition, age, training, education, and experience the petitioner is unfit to perform any but the most menial task for which no stable labor market exists.
    d. Once the petitioner establishes that he or she falls into this odd-lot category, then the burden of proof shifts to the respondent to show the availability of suitable work.

M. **Vocational Rehabilitation**

1. Employer must prepare a vocational rehabilitation plan when both parties determine the injured worker will, as a result of the injury, be unable to resume the regular duties in which he was engaged at the time of the injury, or when the period of total incapacity for work exceeds 120 continuous days.
2. If employer and petitioner do not agree on a course of rehabilitation, the Commission uses the following factors to determine if rehabilitation is appropriate:
    a. Proof that the injury has caused a reduction in earning power.
    b. Evidence that rehabilitation would increase the earning capacity, to restore the petitioner to his previous earning level.
    c. Likelihood that the petitioner would be able to obtain employment upon completion of his training.
    d. Petitioner's work-life expectancy.
    e. Evidence that the petitioner has received training under a prior rehabilitation program that would enable the petitioner to resume employment.
    f. Whether the petitioner has sufficient skills to obtain employment without further training or education.

3. Employer is responsible for payment of vocational rehabilitation services.

N. **Maintenance**

1. Not technically TTD.
2. A component of vocational rehabilitation.
3. Maintenance is paid once claimant at MMI, and undergoing vocational rehabilitation.
4. Two common situations:
   a. When petitioner is undergoing vocational rehabilitation and has been placed at MMI, maintenance picks up where TTD ceases (at the TTD rate) –similar to a continuation of TTD.
   b. When employee has completed a vocational rehabilitation program and has yet to be placed in the labor market.

O. **Wage Differential**

1. Compensates for future wage loss
2. To qualify for wage differential, claimant must show:
   a. A partial incapacity that prevents him from pursuing his or her "usual and customary line of employment."
   b. Earnings are impaired.
3. Employee receives 2/3 of the difference between the average amount he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident.
4. The 2011 Amendment to Section 8(d)(1) now provides that for accidents on or after September 1, 2011, wage differential awards shall be effective only until the Petitioner reaches age 67, or five years from the date that the award becomes final, whichever occurs later.

P. **Ratings**

1. The 2011 Amendments to Section 8.1b of the Act provide that physicians may now submit an impairment report using the most recent American Medical Association (AMA) guidelines.
2. In determining the level of permanent partial disability, the Act states that the Commission shall base its determination on the reported level of impairment, along with other factors such as the age of the Petitioner, the occupation of the Petitioner, and evidence of disability corroborated by the treating medical records.
3. The relevance and weight of any factor used in addition to the level of impairment as reported by the physician must be explained in a written order by the Commission.

VIII. Preferred Provider Program

A. The 2011 Amendments to the Workers' Compensation Act amended Section 8(4) of the Act to allow employers to establish preferred provider programs (PPP) consisting of medical providers approved by the Department of Insurance.
   - The PPP only applies in cases where the PPP was already approved and in place at the time of the injury.
   - Petitioners must be notified of the program on a form promulgated by the Illinois Workers' Compensation Commission.

B. Under the Act, petitioners have 2 choices of treating providers from within the employer's network.
   - If the Commission finds that the second choice of physician within the network has not provided adequate treatment, the employee may choose a physician from outside of the network.

C. A petitioner may opt out of the PPP in writing at any time, but the decision to opt out of the PPP counts as one of the petitioner's two choices of physicians.

D. Under the Section 8(4), if the petitioner chooses non-emergency treatment prior to the report of an injury, that constitutes one of the petitioner's two choices of physicians.

IX. Illinois Workers' Compensation Procedure

A. **Steps of a Workers' Compensation Claim and Appellate Procedure**:
   1. Petitioner files an Application of Adjustment of Claim with the Illinois Workers' Compensation Commission. The Application for Benefits must contain:
      a. Description of how the accident occurred
      b. Part of body injured
      c. Geographical location of the accident
      d. How notice of the accident was given to or acquired by the employer
   2. After Application is filed, the claim is assigned to an Arbitrator. The claim will appear on the Arbitrator's status call docket every three months unless it is motioned up for trial pursuant to 19(b) or 19(b-1).
      a. Three arbitrators are assigned to each docket location. These three arbitrators rotate to three different docket locations on a monthly basis.
      b. One of the three arbitrators assigned to a particular docket location will be assigned the case. If a party requests a 19(b) hearing, the hearing will be held before the assigned arbitrator, even if that arbitrator is not at the docket where the case is located.
   3. If no settlement is reached, the case can be tried before the Arbitrator for a final hearing.

a. Arbitrator is the finder of fact and law, and issues a decision.

B. **Pretrial Procedure**

1. Depositions - cannot take the petitioner's deposition.
2. Subpoenas - easy to get, normally Arbitrator has signed in advance
3. Records of Prior Claims - determine if a credit allowed
   - No credits for person as a whole injuries (including shoulders, which are now treated as person as a whole injuries)
4. Section 12 Medical Examination - petitioner must comply
   a. Used to avoid penalties
   b. Used to investigate petitioner's prior treatment and diagnoses
   c. Can be scheduled at reasonable intervals
   d. Must pay mileage
5. Settlement

C. **Arbitration Procedure**

1. When the Application for Adjustment of Claim is filed, the Commission assigns the docket location (normally within the vicinity of where the injury occurred).
2. Cases appear on the call docket on three-month intervals until the case has been on file for three years, at which point it is set for trial unless a written request has been made to continue the case for good cause. (This request must be received within 15 days of the status call date).
   a. Cases that are more than three years old are referred to as "above the red line," and red line cases are available on the call sheet at the Illinois Workers' Compensation Commission website.
   b. If no one for the petitioner appears on a red line case at the status conference, the case can be dismissed by the arbitrator for failure to prosecute.
3. If a case is coming up on the call docket, a party can request a trial.
   - This request must be served on opposing counsel 15 days before the status call.
   - At the status call, the attorneys will select a time to try the case.
4. If both parties are in agreement, they may request a trial at the monthly call docket.
5. If a case is not coming up on the call docket, and a party has a need for an immediate hearing, the party can file a motion to schedule the case for a 19(b) hearing.
   a. The party requesting the 19(b) hearing must only give the other party 15-days notice.
   b. A 19(b) hearing is not proper where the employee has returned to work and the only benefit in dispute amounts to less than 12 weeks of temporary total disability.

6. A pretrial conference can be requested by either party prior to the start of a trial.
    - The benefit of a pretrial conference is that the same arbitrator over a pretrial conference will hear the actual trial, so the parties will have a good idea how the arbitrator feels about the case or a particular issue.
    - Both parties must consent to a pretrial conference.
7. Emergency Hearings under Section 19(b-1)
    a. Petitioner not receiving medical services or other compensation.
    b. Petitioner can file a petition for an emergency hearing to determine if he is entitled to receive payment or medical services.
    c. Similar to hardship hearings in Missouri
    d. Effectively serves the same purposes as a 19(b) hearing but affixes deadlines.
8. If a case is tried by an arbitrator and the arbitrator's award resolves the case (*i.e.*, the parties do not reach a settlement) medical benefits will remain open.
    - Future medical benefits can only be closed through a settlement agreement.

D. **Appellate Procedure**

1. Arbitrator's decision can be appealed to a panel of three Commissioners of the Illinois Workers' Compensation Commission (ten members appointed by Governor—no more than six members of the same political party).
    a. Must file a petition for review within 30 days of receipt of Arbitrator's award.
2. Decision of the Commissioners can be appealed to the Circuit Court.
3. Circuit Court Decision can be appealed to the Illinois Appellate Court's Industrial Commission Panel.
4. If Appellate Panel finds case significant enough, it will submit it to the Illinois Supreme Court.

X. Penalties Relating to Actions of Employer/Insurer

A. **19(k) Penalty for Delay—PPD, TTD and/or Medical**

1. When there has been unreasonably delayed payment or intentionally underpaid compensation.
2. Penalty is 50% of compensation additional to that otherwise payable under the Act.
3. This section is invoked when the delay is a result of bad faith.
4. Amount of penalty is based on amount of benefits which have accrued.
5. Commission will use Utilization Review as a factor in determining the reasonableness and necessity of medical bills or treatment.
    - Utilization review can also be utilized to avoid penalties.

B. **19(l) Penalty for Delay—TTD**

1. If employer or insurance carrier fails to make payment "without good and just cause"
2. The arbitrator can add compensation in the amount of $30/day not to exceed $10,000.
3. This section invoked even if the payment is not a result of bad faith
4. Generally penalties are not awarded if the employer has relied on a qualified medical opinion to deny payment of benefits.

C. **Employer's Violation of a Health and Safety Act**

1. If it is found that an employer willfully violated a health/safety standard, the arbitrator can allow additional compensation in the amount of 25% of the award.

XI. Penalties Relating to Actions of the Petitioner

A. **Intoxication**

- For accidents <u>before</u> September 1, 2011, if the court finds that accident occurred because of intoxication then injury is not compensable.

1. Intoxication not per se bar to workers' compensation benefits.
2. Intoxication will preclude recovery if it is the sole cause of the accident, or is so excessive that it constitutes a departure from employment.

- For accidents <u>on or after</u> September 1, 2011, the Amended Section 11 of the Act provides that no compensation shall be payable if:

1. The petitioner's intoxication is the proximate cause of the petitioner's accidental injury.
2. At the time of the accident, the petitioner was so intoxicated that the intoxication constituted a departure from the employment.

- The 2011 Amendment provides that if at the time of the accidental injuries, there was a 0.08% or more by weight of alcohol in the petitioner's blood, breath, or urine, or if there is any evidence of impairment due to the unlawful or unauthorized use of cannabis or a controlled substance listed in the Illinois Controlled Substances Act, or if the petitioner refuses to submit to testing of blood, breath, or urine, there shall be a *rebuttable presumption* that the petitioner was intoxicated and that the intoxication was the proximate cause of the petitioner's injury.
- The petitioner can rebut the presumption by proving by a preponderance of the evidence that the intoxication was not the proximate cause of the accidental injuries.

B. **Unreasonable/Unnecessary Risk**

1. If the petitioner voluntarily engages in an unreasonable risk (which increases risk of injury), then any injuries suffered do not arise out of the employment.

C. **Fraud**

1. The 2011 Amendments provide the Department of Insurance with authority to subpoena medical records pursuant to an investigation of fraud.
2. The 2011 Amendments eliminate the requirement that a report of fraud be forwarded to the alleged wrongdoer with the verified name and address of the complainant.
3. The 2011 Amendments provide for penalties for fraud, based on the amount of money involved. These penalties begin at a Class A misdemeanor (less than $300) to a Class I felony (more than $100,000). The Amendments also require restitution be ordered in cases of fraud.

XII. Workers' Occupational Diseases Act - Covers slowly developing diseases that do not arise out of an identifiable accident or occurrence but not repetitive trauma.

A. **Occupational Disease** – "A disease arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment."

B. Exposure can be for any length of time (even if very brief).

C. The employer that provided the last exposure is liable for compensation no matter the length of the last exposure (unless claim is based on asbestosis or silicosis - must be exposed for at least 60 days by an employer for it to be liable).

D. Petitioner must prove he was exposed to a risk beyond that which the general public experiences.

E. Applies only to diseases that are "slow and insidious"

1. e.g., kidney ailment cause from repetitive exposure to liquid coolant.
2. e.g., asthma aggravated by white oxide dust.

XIII. Repetitive Trauma - Covered Under the Workers' Compensation Act

A. Date of Injury for Repetitive Trauma

1. Date of injury is the date on which the injury "manifests itself."
2. "Manifests itself" - General Standard - the date on which both the fact of the injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person—Landmark case: *Peoria County Belwood Nursing Home v. Indus. Commn.,* 505 N.E.2d 1026 (Ill. App. 1987).
3. The *Belwood* Standard has been expanded slightly over the years.
4. Courts have found date of injury to be:
   a. Date injury became apparent to a reasonable person.

b. Last date of work at the employer prior to the disablement (time at which employee can no longer perform his job).

XIV. Third-Party Recovery

A. Workers' Compensation Act prohibits petitioners from bringing tort actions against their employers

B. An injured petitioner may pursue tort action against a third party.

C. The third party has a right to contribution from the employer which is limited to its liability under the Workers' Compensation Acts.

D. Typically respondents can recovery around 70 to 75% of what was paid out in benefits.

XV. Assaults

A. If subject matter causing altercation is related to work then injuries from an assault are compensable.

B. Exception: If the aggressor is injured = no compensation.
   - e.g., Waitresses arguing over tables and the argument turns physical when one waitress strikes the other—this is compensable.

XVI. Minors (under 16 years of age)

A. Receive a 50% increase in benefits even if they fraudulently misrepresent their age.

B. Minors may elect within six months after accident to reject the Workers' Compensation Remedies and sue in civil court (potentially high payout).

XVII. Voluntary Recreational Programs

A. Injuries incurred while participating in voluntary recreational programs do not arise out of and in the course of the employment even though the employer pays some or all of the cost.

B. If the employer orders the employee to participate then the recreational injury is compensable.

XVIII. Second Injury Fund

A. Only pays when employee has previously lost an arm, leg, etc. and subsequently loses another arm, leg, etc. in an independent work accident that results in the employee being totally disabled.

B. Present employer liable only for amount payable for the loss in the second accident.

ILLINOIS WORKERS' COMPENSATION 201

I. A Closer Look at Some Procedural Aspects of Workers' Compensation

A. Case Numbers & Docket / Arbitrator Assignments

1. Once an Application for Adjustment of Claim (Application for Benefits) is filed with the Commission, the case is assigned a case number and to an arbitrator's docket location.
   - The docket site is usually within the vicinity of where the injury occurred or where the petitioner resides.
2. Cases appear on the docket for status hearings on three-month intervals until the case has been on file for three years, at which time it is considered above the "redline."
   - Pre-COVID Procedures required that cases above the "redline" were to be set for trial or dismissed for want of prosecution, unless the parties requested a continuance for "good cause" prior tothe docket call date.
   - If a case is dismissed for want of prosecution, the petitioner has 60 days upon receipt of the notice of dismissal to file a Petition for Reinstatement.
   - Current COVID Procedures as of July 2021 automatically continue all cases,including those above the "redline," regardless of age.
3. Three arbitrators are assigned to a particular zone and they rotate between the three docket sites within that zone on a monthly basis.
   - If a party requests a 19(b) hearing, the hearing will be held before the assigned arbitrator, even if that arbitrator is not at the docket where the case is located.
   - A 19(b) hearing request must be electronically filed at least 15 days before the date of the docket call or status hearing.
   - Current COVID Procedures require the parties to undergo a virtual Pre-Trial Conference prior to any case being set for hearing – including 19(b) hearings.

B. Pro Ses

1. Once the petitioner indicates a willingness to settle their case, the insurer/employer can request a case number to be assigned by the Commission.
2. The petitioner and insurer/employer will receive a Notice from the Commission indicating which arbitrator and docket site the case is assigned.
   - The Notice will also contain the date the case first appears on the

assigned arbitrator's docket call.

3. The parties can appear virtually or usually at any ofthe docket sites within the assigned zone, or at any of the docket sites where the arbitrator will be presiding that month for settlement approval.
    - This expedites the settlement process and allows the parties to obtain settlement approval before the date the case first appears on the assigned arbitrator's docket call, which is usually about 3 monthsafter the case is assigned a case number.

C. Settlement vs. Arbitration

1. If a trial occurs, the petitioner's rights to future medical treatment under Section 8(a) and greater disability under 19(h) automatically remain open. These rights can only be closed by way of settlement agreement.

II. Understanding & Avoiding Penalties for Non-Payment of Benefits

A. Penalties can be assessed against an insurer/employer who unreasonably delays or refuses to pay TTD benefits to the petitioner.

B. A recent Illinois appellate court decision (*O'Neil v. Ill. Workers' Comp. Comm'n*, 2020 IL App (2d) 190427WC (Feb. 4, 2020)) held that penalties cannot be assessed based on failure or delay in authorizing medical treatment.

C. Section 19(k) Penalties

1. May be assessed when there is an unreasonable or vexatious delay or an intentional underpayment of TTD and PPD benefits as well as medical bills.
2. The Commission can award 19(k) penalties at up to 50% of the total amount of benefits due and payable.
3. A delay in payment of benefits greater than 14 days shall be considered "unreasonable," but 19(k) penalties are discretionary rather than mandatory.
4. 19(k) penalties will likely not be awarded against an employer for not paying bills deemed unreasonable or unnecessary by a qualified IME or Utilization Review recommending against that prospective medical treatment.

D. Section 19(l) Penalties

1. May be assessed when TTD benefits are withheld "without good and just cause."
2. The Commission can award $30-per-day up to $10,000 for nonpayment of TTD benefits.
3. When the petitioner makes a written demand for TTD benefits, the insurer/employer must respond in writing within 14 days, setting forth the reason for delay.

- A delay in payment of benefits greater than 14 days creates a rebuttable presumption of an "unreasonable" delay, which can be overcome by reliance on a qualified IME opinion.

4. When the petitioner makes a demand for payment of medical bills, the insurer/employer must respond in writing within 60 days after receiving the outstanding bill if it contains the necessary elements needed to submit the bill the basis for nonpayment or underpayment.
    - The bills likely must be provided to the insurer/employer by the petitioner with the appropriate HCFA or UB-04 form to the insurer/employer.
    - Interest begins accruing at the rate of 1% per month in favor of the healthcare provider if no basis for nonpayment or underpayment is provided by the insurer/employer within the 60-day period.
5. 19(l) penalties usually will not be awarded against an employer if the employer has relied upon a qualified IME opinion.

E. Section 16 Attorneys' Fees
    1. May be assessed when there is an unreasonable or vexatious delay or intentional underpayment of TTD or PPD benefits or medical bills, or the insurer/employer engages in frivolous defenses which to not present a real controversy.
    2. The Commission can award all or any part of the attorney's fees and costs against the insurer/employer.
        - However, typically the Commission will award 20% of the penalties awarded under Section 19(k) above.

F. Strategies to Avoid Penalties
    1. Pay the undisputed portions of an arbitrator or Commission award promptly and immediately upon receipt.
    2. Pay a settlement promptly and immediately upon approval.
        - Section 19(g) allows the petitioner to file a civil court action against the insurer/employer for a delay in payment of the award or settlement.
        - The court can require the insurer/employer to pay attorneys' fees (usually 20% of the award or settlement) as well as the costs incurred by the petitioner for the arbitration and court proceedings.
    3. Notify the petitioner in writing generally providing a basis for denial of benefits when they are suspended, terminated, or in dispute or when a written demand is made by the petitioner.
    4. Obtain a qualified IME or Utilization Review opinion to rely on for denying benefits or medical treatment.

III. Utilizing the Limited Discovery & Investigation Tools

A. Section 12 IMEs

1. The IME doctor can ask about the history/mechanism of injury, review medical records, and provide opinions on causation, additional treatment, restrictions, etc.
    - The IME doctor can also provide an impairment rating.
        i. The Act requires the impairment rating be based on the mostrecent (*e.g.,* Sixth Edition) AMA Guidelines.
        ii. An impairment rating will be one of several factors considered by an arbitrator and Commission when awarding compensation for permanent disability.
2. Can be used to avoid penalties (see above).
3. Can also be used to ask the petitioner about his prior treatment, diagnosis, current complaints, etc.
4. The insurer/employer must provide reimbursement for travel or travel arrangements prior to the IME date, otherwise the petitioner can refuse to appear for the IME.
5. The insurer/employer must provide missed work wages, food, and potentially lodging expenses as well.

B. Subpoenas

1. Forms can be found on the Commission website and can be tailored to your Case Number, body parts injured, and dates of treatment requested.
2. Can help show a more complete picture of the petitioner's post- and pre-injury medical treatment for body parts allegedly injured as a result of the work injury.

C. Prior claims filed by Petitioner

1. Research prior settlements and claims previously received and filed by the petitioner on the Commission website.
    - Credits can generally be taken by the insurer/employer for prior workinjuries to scheduled body parts but <u>not</u> for unscheduled (e.g., bodyas whole) body parts.
2. The Commission website allows the general public to research the database containing this information – although it is limited.

D. Pre-Trial Conferences

1. Current COVID Procedures require the parties to undergo a Pre-Trial Conference with the arbitrator assigned to the case prior to any hearing dates being assigned or set.

- The Pre-Trial date will be set / scheduled by the arbitrator during the docket call / status hearing likely within the next few days or week afterwards.

2. Allows the parties to argue their positions and obtain the arbitrator's opinion about issues, including causation, nature and extent, additional medical treatment, etc.
3. Pre-Trials occur in front of the arbitrator assigned to the case, who will preside at trial if the parties are unable to resolve the case before then.

E. Depositions

1. Cannot take the petitioner's deposition in Illinois.
2. Can take the deposition of the IME doctor to help explain and elaborate on his opinions provided in the IME report.
   - Required to take the deposition of the IME doctor unless petitioner's attorney stipulates to the admission of the IME report, due to hearsay rules of evidence.
3. If the petitioner is unrepresented and voluntarily consents, the insurer can ask the petitioner to provide a recorded or written statement about important facts ofthe case, such as the mechanism of injury, identity of medical providers, etc.

IV. Handling Cases Where a Petitioner Cannot Return to Former Job at the Employer

A. Transitional Light Duty

1. The Commission decided (in March 2019), in *Stegan*, that the petitioner was not entitled to TTD benefits when he refused transitional, light-duty work at a different entity made available by his employer.
   - The *Stegan* employer offered the petitioner light-duty work at Habitatfor Humanity that fell within his restrictions, but the petitioner refusedto attend because Habitat for Humanity was not his employer.
   - The Commission determined the petitioner was not entitled to TTD after his refusal to attend the transitional, light-duty work assignmentbecause he was still to be paid by the employer, remained under thesame policies of the employer, and was by all accounts still considered an "employee" of the employer at the time of the light- duty work.
2. The *Stegan* Commission decision seemingly allows employers to terminate TTD benefits when they can offer transitional, light-duty work within the petitioner's restrictions at another employer so long as remain an employee of the employer (*e.g.,* subject to the employer's policies, is paid by the employer, etc.).

B. Loss of Occupation

1. If the petitioner is unable to return to their former line of work, the arbitrator and/or Commission will likely award an increased PPD percentage to account for that.
    - Typically, arbitrators will award 40-60% BAW for loss of occupation cases, but this can vary based on the significance of the permanent restrictions, the petitioner's age, the kind of work they are engaged in, etc.

C. Wage Differential

1. If the petitioner is unable to return to their former line of work and is only capable of obtaining employment at a lower wage, they can be entitled to awage differential.
    - The insurer/employer is required to provide weekly payments totaling2/3 of the difference between their pre- and post-injury earnings capacity until they are 67 years old or 5 years from the date of the award, whichever is greater.
    - Example: The petitioner earned $1000/week before the work injury,but now the petitioner can only earn $700/week after the work injury.The petitioner is entitled to $200/week until they reach 67 years old or 5 years after the date of the award, whichever is greater.

D. PTD & Odd Lot PTD

1. Arises only when the petitioner is completely disabled and/or unable to find any suitable employment anywhere.
2. Petitioner is entitled to 2/3 of his AWW for the rest of their life.
3. Odd Lot PTD is different from PTD, as it only arises when the petitioner has a disability that is limited in nature such that they are not obviously employable but can prove employment is unavailable to a person in their circumstances.
    - The petitioner must show diligent but unsuccessful attempts to find work, or that they are unfit to perform any certain tasks for which no stable labor market exists because of their medical condition, age, training, education, and experience.
    - The insurer/employer can overcome this situation by showing availability of suitable work.

E. Vocational Rehabilitation

1. When there is no dispute that the petitioner is unable to return to his prior job because of the work injury or the period of total incapacity exceeds 120 continuous days, the employer must prepare a written vocational rehabilitation plan.

2. If there is a dispute, the arbitrator and/or Commission will look at whether: the injury caused a reduction in earnings capacity; vocational rehabilitation will increase their earnings capacity and the likelihood the petitioner will find suitable employment; the petitioner has sufficient skills to obtain employment without further training or education or has undergone similar rehabilitation program(s) in the past; and the petitioner's work-life expectancy.
3. The insurer/employer must pay maintenance benefits when the petitioner is engaged in vocational rehabilitation or undergoing a self-directed job search and cannot return to his prior job or the employer cannot accommodate theirrestrictions.
    - Maintenance is similar to TTD benefits, but is a component ofvocational rehabilitation and paid after the petitioner reaches MMI.
    - The petitioner is not automatically entitled to maintenance benefits in situations where they cannot return to their prior job but do not undergo a self-directed job search or vocational rehabilitation program.

F. Labor Market Survey
1. Helps overcome an allegation of PTD, Odd Lot PTD, and Wage Differential cases by showing the petitioner can return to work at another employer – and possibly that their earnings capacity has not been reduced by the work injury.
2. Performed by a certified vocational counselor who reviews the medical records and attempts to find suitable employment within the petitioner's restrictions.

G. Vocational Assessment
1. Helps further overcome allegations of PTD, Odd Lot PTD, and Wage Differential.
2. The vocational counselor will meet with the petitioner to interview them about their experience, education, training, etc. to better identify certain available job openings at potential employers.

RECENTLY ASKED QUESTIONS IN ILLINOIS

FROM ISSUES ADDRESSED IN RECENT ILLINOIS CASES

Q: Can the act of mailing a signed employment contract from Illinois be considered the "last act necessary" to make Illinois jurisdiction appropriate when the claimant was also required to obtain an Indiana license and subsequently underwent a fingerprint background check in Indiana?

A: Yes, it can be.

Claimant filed an application for adjustment of claim pursuant to the Worker's Compensation Act seeking benefits for injuries she allegedly sustained in Indiana while in the employment of respondent, Aureus Medical Group (Aureus). Employer alleged Illinois jurisdiction was not appropriate.

In this order, Claimant initially contacted the employer (a staffing agency) through its website. She underwent a phone interview while she was in Illinois and was later contacted by the employer while she was in Illinois to tell her about a work assignment, which she accepted. She underwent a physical examination and drug test in Illinois and downloaded the Indiana nursing license application while she was in Illinois, which was mailed to the employer from Illinois. She also downloaded an employment contract while she was in Illinois, which provided a start date, and electronically signed and returned it while she was in Illinois. She underwent a TB test in Illinois and a fingerprint background check in Indiana. The employment contract start date was also modified, and she printed and re-submitted it to the employer from Illinois. Lastly, the job was officially "posted" on an Indiana website.

Claimant sustained a compensable injury while she was working in Indiana. The arbitrator found that Illinois had jurisdiction because the final employment contract was signed and transmitted from Illinois. The arbitrator also found that, although the claimant was required to present for drug test, a background check, tuberculosis check, and have an Indiana nurse's licenses, these acts were only conditions *subsequent* to qualify for the assignment not conditions *precedent* for the hiring of the claimant.

The Commission sided with the arbitrator finding that Illinois jurisdiction was proper. On appeal, the Court of Appeals affirmed the Commission's decision finding that a contract for hire is made where the last act necessary to give validity to the contract occurs. The court found in this case that the signing and transmission of the contract in Illinois was sufficient to constitute the last act necessary to give validity to the contract.

Aureus Med. Grp. v. Illinois Worker's Compensation Comm'n, 2021 IL App (3d) 200201WC-U (April 6, 2021).

Q: Does an injury "arise out of employment" when the employee is performing everyday activities such as bending, stooping, etc. that are connected to or reasonably expected to be performed in fulfilling his duties?

A: Yes, and compensability should be analyzed under the "employment" risk analysis (instead of the "neutral" risk analysis) if the bodily movements are connected to fulfilling their job duties, generally speaking.

Claimant, a sous chef, was setting up his station for his evening shift at work. While doing this, he was asked by a co-worker to locate a missing pan of carrots in the walk-in cooler. Upon doing this, he sustained a knee injury after standing up from a kneeling position while looking for the missing item.

The arbitrator ruled in favor of Claimant, but the Commission reversed, finding that the injury did not arise out of the employment, utilizing the "neutral" risk analysis. The circuit court and appellate courts affirmed the Commission's decision.

But the Illinois Supreme Court reversed that decision, reasoning the evidence established that the injury was caused by an "employment-related risk" because the claimant was engaged in work that the employer would have reasonably expected him to perform. The court then overruled a previous appellate decision, *Adcock v. Illinois Workers' Compensation*, which some appellate courts relied on to require that claimants additionally prove they were exposed to a risk of injury to a greater extent than the public (e.g., under the neural risk analysis), even where the everyday activity is directly related to the claimants' job duties.

In short, the Illinois Supreme Court generally held that if the everyday activities were connected to the claimant fulfilling their job duties, then it's an "employment" risk and the "neutral" risk analysis need not be discussed, as it's a compensable injury.

McAllister v. Illinois Worker's Compensation Comm'n, 2020 IL 124848 (September 24, 2020).

Q: Is an injury compensable when an employee sets his tools down, causing him to lose his balance, in light of the McAllister decision?

A: Potentially, yes.

Claimant was changing a water meter in a customer's basement. After finishing the job, he moved his tool bucket to a chair and sat down. While holding his tools (e.g., channel locks) in his hand, he leaned over to put the tools in the bucket on the chair, when the chair went backwards. This caused him to lose his balance, lean forward, and reach out with his arm to catch himself. As a result, he sustained a torn rotator cuff.

The arbitrator found that the injury arose out of employment, as the act he was performing was related to his job. The Commission affirmed the arbitrator's ruling, specifically citing *McAllister*, and analyzing the case under the "employment" risk analysis. Specifically, the Commission noted that an injury is an "employment" risk

(and compensable without further analysis) if the employee was performing (1) acts instructed to perform by the employer; (2) acts they had a common-law or statutory duty to perform; or (3) acts that the employee might reasonably be expected to perform incidental to assigned duties.

Here, the Commission determined his job duties included putting tools in his bucket and he was required to use a chair to perform his duties. Therefore, the Commission found that sitting in a chair to put away tools was incidental to his employment or job duties and sustained a risk "incidental" or "connected" to his employment. The Commission also found that he was a traveling employee, which further lessened the burden of proof for Claimant.

Peterson v. Toltech Plumbing, 29 ILWCLB 56 (Ill. W.C. Comm. 2021) – 21 IWCC 0095

Q: Is a parking lot injury compensable when the employee stepped from a sidewalk curb to a sloped surface and no defective/hazardous condition were present, other than darker lighting?

A: Probably not.

Claimant fell while on the employer's premises when she was leaving work after clocking out. Specifically, she was walking toward her assigned parking lot. While walking, she stepped from a sidewalk curb to the blacktop parking lot when she fell. Although the blacktop below the sidewalk curb appeared to be level with the sidewalk, it was sloped down, which caused her to trip and fall.

She also testified that at the time of the injury that the area where she fell was darker than usual due to non-working exterior light and a shadow created by a parked vehicle. Despite these alleged defects, she also conceded that the area where she fell was free of any defects and photographs entered into evidence supported that the area was free of hazardous or defective conditions. The employer also maintained the sidewalk where she fell was available to and used by the general public.

The arbitrator initially found in favor of Claimant, citing *Litchfield Healthcare Center* (where the employee fell on uneven concrete slabs). The arbitrator found the risk of tripping on uneven slabs was a "neutral" risk to which Claimant was exposed to a greater degree than the general public. But the Commission reversed, citing *Caterpillar Tractor Co*, finding that there were no defects or hazardous conditions that exposed her to a greater risk of injury than the general public. The Commission noted, "curbs are, by nature, raised boundaries" and that the height difference between a curb and the parking lot was "by design" rather than a defect or hazardous condition. Further, the Commission highlighted the employer's argument that "common sense dictates that sidewalk slabs should be even or at the same height; whereas curbs are, by nature, raised boundaries."

The appellate court affirmed the Commission's decision and held that "the possibility of mis-stepping while stepping from a sidewalk, over a curb and onto a slanted surface

in close proximity to an access ramp is not a risk peculiar to Claimant's employment where there is simply no evidence of a defect." So, the court held that the injury did not arise from an employment risk or a neutral risk to a greater degree than the general public.

Vaughan v. IWCC, 2021 IL App (4th) 200253WC-U

Q: Is an injury compensable if an employee hops over a chain rather than using the sidewalk while walking to drop off her time card, as required by her job?

A: Likely not.

Claimant was on her way to drop off her time card, as required by her temporary employee job description with the employer, when she sustained injuries to her elbow. She was not directed by the employer about which route to take and she was not, per se, required to drop off her time card during work hours – although she testified she always did.

On the date of injury, Claimant hopped over a chain barrier along a sidewalk on her way to drop off her time card. The heel of her shoe got caught on the chain, and she fell and suffered injury to her elbow. She admitted there was no defect with the fence or ground below and she conceded she could have taken a different route that did not require her to jump over a chain, which would have been a safer alternative.

The arbitrator found that she was not a "traveling employee" and denied compensation. The arbitrator also found that her injury was an "idiopathic" or "personal" risk rather than an "employment" or "neutral" risk, so compensation was denied. The Commission upheld the arbitrator's decision, holding that her accident did not arise out of her employment. Claimant's decision to hop over chain fence, rather than use the walkway, was for her own benefit, and she voluntarily exposed herself to an unnecessary personal danger. Thus, injury did not arise out of employment as a non-traveling employee. Record supports Commission's conclusion that travel was not an essential element of Claimant's employment.

Purcell v. Illinois Workers' Compensation Comm'n, 2021 IL App (4th) 200359WC (April 27, 2021)

Q: Do the exclusivity provisions of the Worker's Compensation Act bar a claim for statutory liquidated damages, where an employer is alleged to have violated an employee's statutory privacy rights under the Biometric Information Privacy Act (BIPA)?

A: No, the Act does not bar BIPA claims. But the workers' compensation claim is not compensable under the Act.

Claimant filed a class action lawsuit against her employer alleging that her employer required her to provide biometric information by requiring her to use a fingerprint scanner for purposes of utilizing a fingerprint-based clock system. Claimant alleged

her employer negligently collected this biometric information without properly giving notice of use, collection, or storage in advance and in writing. Claimant sought injunctive and equitable relief requiring defendants to comply with the Privacy Acts requirements, liquidated damages of $1,000 for each defendant, and statutory attorney fees and costs.

In this case, the court made sure to clarify that it was evaluating the applicability of the Worker's Compensation exclusivity provision to the liquidated damages and not the actual damages available under the Privacy Act. The court points out that there is no common law or statutory right to recovery for an employee covered by the Act unless the injury was not accidental, did not arise from employment, not received during course of employment, or not compensable under the Worker's Compensation Act. The court ultimately comes to the conclusion that although the Worker's Compensation Act does not preempt the Privacy Act, it is not compensable.

McDonald v. Symphony Bronzeville Park LLC, 2021 IL App (1st) 192398 (September 18, 2020).

Q: Is a solely psychological injury compensable for a workers' compensation claim?

A: Yes.

Claimant was a police officer employed by respondent, the City of Elgin. The Commission found he had sustained a psychological injury, post-traumatic stress disorder, in subduing a prisoner who was trying to escape. The Commission subsequently ordered the City of Elgin to pay temporary total disability benefits, temporary partial disability benefits, and medical expenses. The City of Elgin sought judicial review and the circuit court of McHenry County confirmed the Commission's decision.

On appeal, the 2nd District Court of Appeals affirmed the circuit courts finding. The Court of Appeals found that although mental disability was compensable only if it was precipitated by physical contact or injury, this is no longer the standard. The new standard is the "mental-mental" view, finding that if the psychological injuries were caused by sudden, severe emotional shock traceable to a definite time and place and cause even though no physical trauma or injury was sustained, the injury can be compensable.

City of Elgin v. Illinois Worker's Compensation Comm'n, 2020 IL App (2d) 190713WC-U (November 18, 2020).

Q: Is a petitioner entitled to workers' compensation benefits from an injury sustained at a bus stop waiting for a bus ride to work?

A: Not likely.

Petitioner was an attorney, who no longer practiced day to day but instead supervised the office, tried cases, and dealt with major clients. One day the petitioner was asked to meet with a client at the office to which he decided to take the bus. While waiting for the bus, petitioner tripped on the edge of the sidewalk slab and fell on his shoulder. He was helped to his feet and taken to the hospital in a cab. He subsequently reported the injury to the office manager and informed them he would not be into the office. Petitioner was diagnosed with a torn rotator cuff.

On appeal, the question was whether the facts come within the legally recognized exception to the coming and going rule. The court found that the sidewalk that petitioner stood at was not a usual access route, that the petitioner was not an employee actively at work while in route, and although it is not settled whether he was an "on call" employee, the injury did not occur while he was not engaged in the direct performance duties assigned or directed by the employer. The court also found that the petitioner did not fit the standard for the special mission/errand exception or as a traveling employee affirming that he was not entitled to worker's compensation.

Brustin v. Illinois Worker's Compensation Comm'n, 2021 IL App (1st) 200502WC-U (January 8, 2021).

Q: If a claimant returns to full duty employment and did not seek subsequent medical treatment until 4 months later, can they still be awarded workers' compensation benefits for that injury?

A: Yes.

Claimant filed two applications for adjustment of claims pursuant to the Workers' Compensation Act. The first application sought benefits for injuries he allegedly sustained while working in December and the second application sought benefits for injuries he alleged he sustained while working in April. After the first accident occurred when claimant slipped and fell on ice, Claimant sought emergency treatment and reported the back and neck injury to the employer's insurer but was never provided with authorization to seek further medical treatment. The second injury occurred as an aggravation of the first from driving on a bumpy road. After the second injury, the claimant again sought emergency treatment for back and left leg pain. After IMEs, claimant was found to have a herniated disc and early degenerative changes in other discs in his back.

Claimant did not report the second injury and did not request authorization for medical treatment for four months after the first injury. During arbitration, it was found that the second injury was not a separate injury. The Commission ordered the employer pay the claimant's emergency related treatment and other reasonable related medical expenses for the first injury only. The Commission also vacated the TTD benefits and reduced the PPD benefits awarded by the arbitrator. The Commission's decision was confirmed by the circuit court of Peoria County and the 3rd District Court of Appeals.

Maroney v. Illinois Worker's Compensation Comm'n, 2021 IL App (3d) 200213WC (April 6, 2021).

Q: Can an employer receive a credit for vacation or sick leave pay against TTD owed when the employee took the vacation or sick leave during the time period for which the TTD covers?

A: Sometimes yes, if the employer does not have a policy implying that the employee can receive both benefits at the same time.

In *Terri Clayton v. Illinois Veterans Home*, the Commission held that Respondent owed TTD benefits for 2 and 5/7th weeks, but Respondent was entitled to a credit under section 8(j) of the Act for the vacation days the petitioner used during her lost time.

The Commission discussed two Illinois Appellate Court cases, *Tee-Pak, Inc. v. Industrial Comm'n* (1986) and *Elgin Board of Education School District U-46 v. Illinois Workers' Compensation Comm'n* (2011). In *Tee-Pak* there was evidence from which the Commission could infer that the employer intended its employees to collect both TTD benefits and salary payments for the same time period. In *Elgin*, there was no evidence that Respondent had a policy allowing collection of both benefits at the same time, therefore the limitation imposed in *Tee-Pak* did not apply.

The Arbitrator in this case took special note of—and the Commission reiterated—the Illinois Administrative Code which provided that "…employee shall be permitted to utilize accumulated sick leave or other benefits unless the employee has applied for and been granted temporary total disability benefits in lieu of salary or wages pursuant to [the Act]…" and "…employee shall restore the State the dollar equivalent which duplicates payment received as sick leave or other accumulated benefit time, and employee's benefit accounts shall be credited with leave time equivalents." The petitioner argued that vacation payments are a benefit that can be utilized by an employee regardless of the occurrence of a work-related accident. Respondent then argued that section 8(j) of the Act provides for a credit for vacation days when received in lieu of TTD benefits, unless the employer's policies allow for receipt of both benefits. Respondent argued further that the State's policy governing this issue is clearly outlined in the Illinois Administrative Code.

Accordingly, the Commission held that Respondent is liable for TTD benefits, but a credit is awarded only against payment by the State of the awarded TTD payments. The petitioner is not required to repay the State for any such credit awarded until after the receipt of the TTD award payment.

Terri Clayton, Petitioner, 16 IL. W.C. 12828 (Ill. Indus. Com'n Feb. 27, 2020).

Q: Does the employee-employer relationship exist when the petitioner is not receiving any pay and has no expectation of gainful employment to result from

the work performed for Respondent, but Respondent provides the equipment and directed the petitioner on how to perform her duties?

A: Likely not. Although Respondent controlled the petitioner's work, the employee-employer does not exist without an express or implied contract for hire.

In *Hanna Larson v. Quad City Skydiving Center*, the Commission held that an employer-employee relationship did not exist on the date of injury. The petitioner wanted to increase her number of flight hours and Respondent indicated they were looking for an additional pilot. The petitioner testified that the flying hours she logged while working for Respondent went towards the requirements of her airline transit pilot certificate. That certificate was necessary to obtain her current job as a commercial pilot. Respondent provided the plane, paid for gas, and provided instructions on where to fly.

The petitioner did not sign an employment contract and agreed to work as an unpaid pilot. The petitioner testified it was a mutually beneficial relationship because she did not have to pay to rent a plane to obtain her flight hours, and during her flights an employee for Respondent was able to instruct additional skydivers. The petitioner neither received nor expected money and never received any tax documents. Respondent was not responsible for keeping track of her flight hours and did not have to sign off on the hours. The petitioner sustained injuries when landing a plane for Respondent's skydiving operations.

The Commission stated that an employee-employer relationship cannot exist under the Act absent a contract for hire, either express or implied. The petitioner admitted she had no expectation of receiving payment and did not expect the opportunity would lead to gainful employment by Respondent. Therefore, the Commission found that the petitioner did not meet her burden in proving the existence of an employee-employer relationship.

Hannah Larson, Petitioner, 15 IL. W.C. 22225 (Ill. Indus. Com'n Jan. 20, 2020)

Q: Can an arbitrator merge permanency awards when the petitioner sustains two separate and distinct injuries to the same body part and the claims are consolidated for hearing?

A: No, so long as the injuries are found to be distinct from one another and the second injury does not simply aggravate the first injury.

In *Donald Haepp v. City of Chicago*, the Commission held that the arbitrator should not have merged the permanency awards but instead, the petitioner was entitled to separate awards. On May 4, 2010, the petitioner sustained a meniscus tear in his left knee. He then reinjured his left knee on January 26, 2011. The arbitrator found that the petitioner was entitled to 20% loss of use of the person as a whole because the petitioner was partially incapacitated from pursuing the duties of his usual and customary line of employment.

The Commission stated that when a petitioner has sustained two separate and distinct injuries to the same body part and the claims are consolidated, it is proper to consider all of the evidence presented to determine the nature and extent of his permanent disability as of the date of hearing. The Commission noted that in past cases the Appellate Court did not specify whether to administer one combined award or two separate awards. The only restriction provided by statute is in Section 8(d)1 which provides that a scheduled PPD award and a wage-differential award cannot be awarded at the same time. Further, the Commission pointed out that other cases deal with instances where the petitioner had two accidents that resulted in one injury, or, an injury and a subsequent aggravation of that injury. Here however, the Commission found that the petitioner experienced two completely separate injuries to the same body part. Specifically, the petitioner sustained a meniscus tear and underwent surgery. Following his recovery, he sustained an additional meniscus tear to a different area of his meniscus on the same knee that was not identified during the first surgery. Therefore, the Commission held that the petitioner sustained two compensable injuries from two separate accidents, and accordingly held it appropriate to award two separate PPD awards for each accident.

Donald E. Haepp, III, Petitioner, 10 IL. W.C. 25879 (Ill. Indus. Com'n Sept. 16, 2019).

Q: Can a petitioner prove accident and causation without presenting testimony of an expert?

A: Yes, if the petitioner can prove causation under a chain of events theory.

In *Jefferey Stone v. Stork's Mower Shop*, the Commission held that although the petitioner did not provide expert testimony to show that his work activities caused the condition of ill-being, the petitioner met his burden of proving accident and causation.

The petitioner was a 52-year-old small engine mechanic. On one particular day he worked on six or seven different engines, each of which he had to pull-start multiple times. The following day the petitioner was unable to pick up a cup of coffee with his right arm. He presented to a doctor and was diagnosed with a shoulder strain and given an injection and physical therapy. Respondent argued that the Arbitrator erred in finding that the petitioner proved accident and causation without any supporting expert testimony. The Commission advised that the petitioner testified he had no problems with his right shoulder prior to the date of injury, had no medical treatment on his right shoulder prior to that date, and did not previously have any issues performing his job duties. The Commission held that the absence of prior symptoms and issues in the shoulder, combined with the evidence that he had to pull start multiple motors and experienced symptoms in his shoulder the following day was enough prove causation.

Jeffrey Stone, Petitioner, 11 IL. W.C. 4883 (Ill. Indus. Com'n Sept. 25, 2019).

Q: Can a request to submit video surveillance into evidence at trial be denied even if the petitioner identifies themselves in the video during trial?

A: Yes, if the other evidentiary requirements are not met.

In *Anthony Bridges v. Chicago Transit Authority*, the Commission reversed the Arbitrator's decision to admit video surveillance into evidence that was relevant to whether the petitioner experienced a compensable injury. At trial, Respondent offered the video into evidence, but the petitioner's counsel objected noting its altered form and the inconsistent speed of the video. Respondent's counsel acknowledged technical issues related to the vide software and the Arbitrator noted difficulty in controlling the playback speed of the video.

The Commission found that although the video was relevant to whether the petitioner sustained a compensable accident at work, it was not properly authenticated, and the accuracy of the video was brought into question. Specifically, the Commission indicated that to properly authenticate video surveillance, a foundation must be laid by someone having personal knowledge of the filmed object that can testify that the video is an accurate portrayal. Further, verification may be furnished by testimony of any competent witness who has enough knowledge to testify that the videotape fully represents what it is trying to portray. Here, although the petitioner identified himself in the video, his testimony did not establish that the video is an accurate and full representation of what it purports to show. Therefore, Commission held that the video surveillance was entered into evidence in error.

Anthony Bridges, Petitioner, 17 IL. W.C. 17575 (Ill. Indus. Com'n Sept. 30, 2019).

Q: Is an injury compensable when the petitioner has no immediate complaints of pain and there is no initial mention of any accident or injury associated with the medical condition?

A: Sometimes yes, but it is very fact intensive.

In *Shelly Moore v. Bethalto Community Unit School District 8*, the Commission held that the petitioner's shoulder injury was causally related to the stipulated work accident. The petitioner was a high school science teacher and while pulling down a projector screen which was attached to the ceiling, the screen fell and hit her left wrist. The school nurse had the petitioner complete an injury report which indicated that the petitioner injured her wrist but did not address any shoulder injury. The petitioner received conservative care for her wrist and noted that she previously had arthritis in her left shoulder. Approximately three weeks after the accident, the petitioner treated with a physician with complaints of left shoulder, clavicle, and neck pain. The petitioner later testified that the screen struck her left shoulder, but she did not feel immediately shoulder symptoms because she was focused on her wrist. There were doctors who provided conflicting reports related to causation.

The Commission reversed the Arbitrator's decision noting that although there were no initial symptoms reported in the shoulder, and no mention of the shoulder injury being related to the work accident when she presented to a physician weeks later, the injury was compensable. Specifically, the Commission relied on a physician's opinion that an acute more painful injury, in this case the petitioner's wrist, could mask the symptoms from another less acutely painful injury which may ultimately be significantly more severe.

Shelly Moore, Petitioner, 16 IL. W.C. 24012 (Ill. Indus. Com'n Oct. 2, 2019).

Notes Pages

Notes Pages

Notes Pages

IOWA WORKERS' COMPENSATION

I. PERSONAL INJURY

A. Accident/Injury – *Almquist v. Shenandoah,* 218 Iowa 724, 254 N.W. 35 (1934)

1. Personal injury:
   a. An injury to the body, the impairment of health, or a disease, which comes about not through the natural building up and tearing down of the human body, but because of a traumatic or other hurt or damage to the health or body of an employee. The injury to the human body must be something that acts extraneously to the natural processes of nature, and thereby impairs the health, overcomes, injures, interrupts, or destroys some function of the body, or otherwise damages or injures a part or all of the body.
   b. Repetitive trauma:
      i. The injury to the body in repetitive trauma cases occurs when pain or physical inability prevents the employee from continuing to work.
2. An injury, to be compensable, must arise out of and in the course of the employment:
   a. "Arise out of" – requires proof of a causal connection between the conditions of the employment and the injury. The injury may not have coincidentally occurred while at work, but must in some way be caused by or related to the working environment or the conditions of the employment.
      i. Special Cases—
         (1). *Actual risk*: an injury is compensable if the employment subjected the claimant to the actual risk that caused the injury, i.e. some causative contribution by the employment must exist.
         (2). *Idiopathic causes*: compensable only if caused or precipitated in part by some employment-related factor, or that the effects of the injury were worsened by the employment.
         (3). *Horseplay:* non compensable when an employee of his or her own volition initiates or actively takes part in an activity that results in injury. Victim/nonparticipant will be compensated.
         (4). *Assault*: generally compensable if it arises from an actual risk of the employment. If the assault is a willful act of a third party directed against the employee for reasons personal to the employee, then it will not be compensable.
   b. "In the course of" – the injury must take place within the period of the employment, at a place where the employee reasonably may be, and while the employee is fulfilling work duties or engaged in activities incidental thereto.
      i. *Coming and going*: an accident that occurs while an employee is going to or coming from work does not arise out of and in the course of employment.
      ii. Exceptions:

(1). *Employer-supplied transportation*: when an employer controls the situation, i.e. route and operation of the vehicle, the employee is being transported to an intended place of employment, injuries sustained are generally compensable.

(2). *Dual purpose trips*: If a trip is both personal and for services to the employer, an injury will only be compensable if canceling the trip would have caused the employer to send someone else.

(3). *Special errand*: a trip that would not be covered under the usual going and coming rule may be brought within the course of employment if the trip to and from the employer's premises were a special trip made in response to a special request, agreement, or instructions.

(4). *Parking lots*: employer parking lots are generally considered part of the employer's premises, but the injury must also occur within a reasonable time limitation related to, or occasion by, the employment.

(5). *Sole mission*: a plaintiff incurs the risk of injury while solely on a mission for his or her own convenience if there is no connection between plaintiff's work and his or her injury.

B. Occupational Disease – Defined by Statute, chapter 85A
   1. Occupational disease § 85A.8
      a. An occupational disease means a disease which;
         i. arises out of and in the course of employee's employment,
         ii. is the result of a direct causal connection with the employment and;
         iii. follows as a natural incident thereto from an injurious exposure it occasioned by the nature of the employment
      b. The disease must be incidental to the character of the business and not independent of the employment.
      c. Contraction of the disease must have an origin connected with the employment
      d. Hazards to which the employee would have been exposed to outside of the occupation are not compensable as an occupational disease.
   2. Applicable to all "employers" and "employees" as defined by the Iowa Workers' Compensation Act.
   3. Relates to the last occupation in which the employee was injuriously exposed to the hazards of the occupational disease. § 85A.10
      a. Limitations on Disablement or Death from Occupational Disease
         i. No recovery shall be had under Iowa Occupational Disease statute for any condition which is compensable as an "injury" under Iowa Workers' Compensation Act. § 85A.14
         ii. Compliance with the findings and orders of the Commissioner or Court shall discharge the employer and carrier for all future obligations under the Iowa Occupational Disease statute. § 85A.15

iii. An employer shall not be liable for compensation for an occupational disease unless:
(1). Disablement or death results within three years in the case of pneumoconisis.
(2). Employee makes a claim within 90 days after employee knew, or should have known, of disablement or death for exposure caused by X-rays, radium, radioactive substances or machines, or ionizing radiation.
(3). Disablement or death results within 1 year for all other occupational diseases.
(4). Death from an occupational disease results within seven years after an exposure following continuous disablement which started within one of the aforementioned periods.
(5). "Disablement " – § 85A.4
(a). is the occurrence of an event or condition which causes the employee to become actually incapacitated from performing work or from earning equal wages and other suitable employment as a result of the occupational disease.

4. Compensation – IA § 85A.5
   a. Employees who become disabled because of an injurious exposure are entitled to receive "compensation" and reasonable medical treatment. § 85A.17
      i. Compensation is payable to all "dependants" as defined by the Iowa Workers' Compensation Act.- § 85A.6.
   b. Employees that incur occupational disease, but are able to continue in employment, are not entitled to compensation but are entitled to reasonable medical treatment.
5. Apportionment – § 85A.7(4)
   a. Where an occupational disease is aggravated by a non-compensable disease or infirmity, or, a non-compensable disease or infirmity is aggravated by an occupational disease, compensation shall be in proportion to the amount that is solely caused by the occupational disease.
   b. Either the number of weekly payments, or the amount of such payments, may be reduced as determined by the Commissioner.
6. Exclusions – § 85A.7
   a. Employees are not entitled compensation if they misrepresent, in writing, that they had not been previously disabled, terminated, compensated, or missed work because of an occupational disease.
   b. Compensation for existing diseases shall be barred if the employer can prove the disease existed prior to the employment.
      i. The employer shall have the right to have an employee examined prior to employment and may require a waiver, in writing, of any and all compensation due to an occupational disease. § 85A.25

c. Compensation for death shall not be payable to any dependent whose relationship to the deceased employee was created after the beginning of the first compensable disability.
    i. This rule does not apply to children born after the first compensable disability to a marriage existing at the beginning of such disability.
d. Miscellaneous exclusions: no compensation shall be allowed if the occupational disease:
    i. is the result of an employee intentionally exposing themselves to the occupational disease;
    ii. is the result of the employees intoxication;
    iii. is the result of employees addiction to narcotics;
    iv. as a result of the employees commission of a misdemeanor or felony;
    v. as a result of employees refusal to use the safety appliance or protective device;
    vi. as a result of employees refusal to obey a reasonable written rule, made by the employer, and posted in a conspicuous position in the workplace;
    vii. as a result of the employees of failure or refusal to perform or obey a statutory duty;
    viii. The employer bears the burden of establishing these defenses.

C. Hearing Loss – Defined by Statute, § 85B.5

1. Occupational Hearing Loss is the portion of permanent hearing loss that exceeds average hearing levels that arises out of and in the course of employment and is causally related to excessive noise exposure.
    a. 25 decibels in either ear is equivalent to a 0% hearing loss.
    b. An average of 92 decibels in either ear is equivalent to a 100% hearing loss.
2. Applicable to all "employers" and "employees" as defined by the Iowa Workers' Compensation Act.
3. Limitations:
    a. Occupation Hearing Loss does not include loss of hearing attributable to age or any other condition or exposure not arising out of and in the scope and course of employment.
    b. Compliance with the findings and orders of the Commissioner or Court shall discharge the employer and carrier for all future obligations under the Iowa Occupational Hearing Loss statute. § 86B.13
4. Compensation
    a. A claim for compensation for hearing loss may not be made unless and until there is a change in the claimant’s employment situation generally as the result of the occurrence of any one of the following events:
        i. Transfer from excessive noise exposure employment by an employer;
        ii. Retirement;
        iii. Termination of the employer-employee relationship, which may include simply a change in ownership of the business

b. Compensation for Occupational Hearing Loss is calculated using 175 weeks for total loss, and a proportional period of weeks relating to partial hearing loss.
c. Determination of hearing loss shall be made by the employer's regular or consulting physician or a licensed, trained, and experienced audiologist.
d. If the employee disputes the assessment, he or she may select a physician or licensed, trained, and experienced audiologist to provide an assessment.

5. Apportionment
   a. Any amounts paid under this section by a previous employer, or under a previous claim, shall be apportioned and the employer is only liable for the increase in hearing loss sustained in the scope and course of employment.
6. Employer/Employee Duty:
   a. Employees have an affirmative obligation to submit to periodic testing of their hearing.
   b. If, after testing, the employer learns that the employee's hearing level is in excess of 25 decibels, the employer must inform the employee as soon as practicable after the examination.
   c. Employers have an affirmative obligation to inform employees if they are being subjected to sound levels and duration in excess of the acceptable limits as indicated in IA § 85B.5.
   d. An employer liable for an employee's occupational hearing loss under this section must provide the employee with a hearing aid, unless the hearing aid will not materially improve the employee's ability to communicate. § 85B.12
7. Notice
   a. An employee may file a claim for Occupational Hearing Loss, at the earliest, one month after separation of the employment which caused the hearing loss with a two year statute of limitations.
   b. The date used for calculating the "date of the injury" shall be the date the employee:
      i. Was transferred from the environment causing the hearing loss;
      ii. Retired;
      iii. Was terminated from employment.
   c. In the event an employee is laid off for longer than one year, the Occupational Hearing Loss must be reported within six months after the date of the layoff.
8. Exclusions
   a. If an employee fails to use, or refuses, employer-provided hearing protective devices, as long as the opportunity and requirement are communicated to the employee in writing.
   b. An employee's failure to submit to period testing in accordance with IA 85B.7 precludes recovery under this section.

c. If an employee's prior hearing loss is tested and documented, and the employee sustained a prior hearing loss, the employer is only liable for the increase in hearing loss under the Occupational Hearing Loss Act.

D. Mental claims – compensable where the injury arose out of and in the scope and course of employment
    1. Employee has the burden of proving cause in fact and legal causation.
        a. Cause in Fact – Supported by competent medical evidence.
        b. Legal Causation –
            i. whether the stress is greater than that experienced by similarly situated employees. *Dunlavey v. Economy Fire.*
            ii. manifest happening of a sudden traumatic nature from an unexpected cause or unusual strain. *Brown v. Quik Trip.*
    2. When a scheduled physical injury aggravates or causes a compensable psychological injury, the psychological injury is compensable as an unscheduled injury. *Mortimer v. Fruehauf Corp.,* 502 N.W.2d 12, 1993 Iowa Sup. LEXIS 146 (Iowa 1993).

II. JURISDICTION - IA Code §85.3, §85.71

A. Act will apply where:
    1. The injuries occurred or occupational disease was contracted in Iowa while in the scope and course of employment.
    2. Employer is a resident of Iowa.
    3. Employer is a nonresident of Iowa, but for whom services are performed within Iowa by any employee.
    4. The employer corporation, individual, personal representative, partnership, or association has the necessary minimum contact with Iowa.
    5. The injury occurred outside of the territorial limitations of Iowa, if:
        a. The employer has a place of business in Iowa, and;
            i. The employee regularly works from that place of business, or;
            ii. The employee is working under a contract which selects Iowa as the forum state.
        b. The employee is working under a contract of hire made in Iowa, and the employee;
            i. Regularly works in Iowa, or;
            ii. Sustains an injury for which compensation is unavailable in the other possible jurisdictions, or;
            iii. Works outside of the United States.

B. Act will not apply where:
    1. Injured worker is covered by a federal compensation statute. *Isle of Capri Casino v. Wilson*, 2009 Iowa App. LEXIS 1446 (Iowa Ct. App. Sept. 2, 2009)
    2. The employee is engaged in service in a private dwelling and earned more than

$1500 in the previous 12 consecutive months before the injury, provided that the employee is not a relative of the employer. IA 85.1

3. The employer engages in agricultural operations, as long as the employee earned more than $1500 in the previous 12 consecutive months before the injury. This exclusion always applies to relatives of the employer, officers of a family farm Corporation, and owners of agricultural land. IA 85.1

C. Dual jurisdiction claims:
    1. Any action filed in Iowa shall be stayed if an employee or employee's dependents initiate a workers' compensation case for the same injury in a separate jurisdiction, but no order, settlement, judgment, or award has been had, pending the resolution of the out-of-state claim for benefits. IA § 85.72
        a. The employer/insurer must file for a stay of proceedings for the stay to be granted.
    2. If the employee or employee's dependents have initiated another workers' compensation case in a separate jurisdiction and benefits have been paid pursuant to a final settlement, judgment, or award, the employee or employee's dependents may not also seek benefits in Iowa. § 85.72

III. NOTICE – § 85.23

A. Notice of an injury is required within 90 days from the date of the "occurrence" of the injury.
    1. For purposes of the statute, "date of the occurrence of the injury" means the date that the employee knew or should have known that the injury was work-related.

B. If an employer has actual knowledge of the injury there is no need to give notice.

C. The employee or someone on the employee's behalf or a dependent or someone on the dependent's behalf may provide notice

D. Payment of compensation shall be conclusive evidence of notice of an employee's alleged work-related injury.

IV. REPORTING REQUIREMENTS § 86.11

A. FROI – First Report of Injury
    1. The employer or insurance carrier must electronically file a First Report of Injury:
        a. Within four days of receiving notice or knowledge of an injury, if:
            i. The injury results in temporary disability for a period longer than three days, or;
            ii. The injury results in permanent total disability, permanent partial disability, or death.

b. If the Commission sends a written request to the employer or insurance carrier.

2. The time period for calculation excludes Sundays and legal holidays.
3. A First Report of Injury is required even if liability is denied—it is not considered an admission of liability.
4. An Agency file number will not be assigned and the claim cannot be settled if the FROI has not been filed. The FROI must be filed through EDI. The Agency will not accept a paper FROI.
5. A $1,000 fine will be imposed if FROI is not filed within 30 days of notification from the Commissioner that a FROI must be filed.

B. SROI – Subsequent Report of Injury
   1. Following the filing of a First Report of Injury, a Subsequent Report of Injury must be filed in the event:
      a. A claim is denied (in addition to a denial of liability letter);
      b. weekly compensation benefits are paid (filed 30 days after the date of the first payment);
      c. Whenever weekly compensation payments are terminated or interrupted;
      d. Whenever a claim is open on June 30 of each calendar year;
      e. When a claim is closed;
      f. Whenever “other” benefits are paid, ie medical, mileage, burial, interest, vocational rehabilitation, and penalties.

C. Medical reports must be filed if the injury exceeds thirteen weeks of temporary total disability or when there is permanent partial disability.

D. Final Reports must be filed showing the date of last payment in the employee's last known address.

V. LIMITATION OF ACTIONS § 85.26

A. An employee must file an Original Notice and Petition with the Commission;
   1. Within two years of the occurrence of the accident or injury under the Workers’ Compensation Act,
      a. Begins running the date the claimant knows they have sustained a work-related injury. For purposes of the statute, “date of the occurrence of the injury” means the date that the employee knew or should have known that the injury was work-related.
   2. Within three years of the date of last payment if weekly benefits are paid pursuant to § 86.13.
   3. Within three years of approval of a settlement or issuance of an award.

B. In an original proceeding, all issues subject to dispute are before the Commission. In a proceeding to reopen an award or settlement, the inquiry will be limited to whether

or not the employee's condition warrants an end to, diminishment of, or increase of compensation awarded or agreed upon.

VI. ANSWER TO PETITION – IA Administrative Code § 876.4.9(1)

A. Upon receipt of Notice of a Contested Case, the Employer shall answer or file a motion within 20 days.

B. All medical records and reports in possession of the Employer/Insurer must be served on all opposing parties within 20 days of filing the Answer and on a continuing basis within 10 days of receipt of the records.

C. Failure to do either of the above could lead to possible penalties including preclusion of evidence, sanctions, or judgment by default.

VII. MEDICAL TREATMENT – § 85.27

A. Employer is responsible for all reasonable surgical, medical, dental, osteopathic, chiropractic, podiatric, physical rehabilitation, nursing, ambulance, and hospital services and supplies, plus reasonable and necessary transportation expenses incurred for such services.
    1. If compensability is admitted, employer is not responsible for unauthorized care, unless the employee shows that the unauthorized care was successful and beneficial toward improving the employee's condition in a way that benefits the employer as well as the employee.

B. The employer's obligation to provide reasonable and necessary medical care carries with it the right to select the treating physician, provided that the care is offered promptly and is reasonable suited to treat the injury without undue inconvenience to the employee. *McKim v. Meritor Auto., Inc.,* 158 F. Supp. 2d 944 (S.D. Iowa 2001).
    1. Exceptions - The employer is not entitled to select the provider when:
        a. Emergency care is necessary because of an actual work-related event.
        b. The employee notifies the employer in writing of his or her dissatisfaction with the employer's provider and provide reasonable proofs of the necessity of alternate care.
        c. The employer denies the claim.

C. If the employer pays medical benefits under a group plan, the amounts paid by the group plan shall be deducted from the amounts paid under the Workers' Compensation Act.

D. If the employer believes the charges of a medical provider are excessive, the employer has the right to have the issue decided by the Commission.

E. The employer, insurance carrier, or employee waive any claim of privilege by virtue of filing or defending a workers' compensation claim. Failure of a medical provider to provide medical records may result in a Court order imposing penalties or sanctions on the provider.

VIII. VOCATIONAL REHABILITATION – § 85.70

A. To be entitled to vocational rehabilitation benefits, an employee must be unable to return to gainful employment because of a job-induced disability and must have permanent partial or permanent total disability.

B. For injuries sustained after September 8, 2004, benefits may be available from the employer in the form of:
   1. $100 per week for 13 weeks,
   2. An additional $100 for 13 weeks if the employee can show that the continuation of benefits will accomplish rehabilitation.

C. For injuries sustained prior to September 8, 2004, benefits may be available from the employer in the form of:
   1. $20 per week for 13 weeks,
   2. An additional $20 for 13 weeks if the employee can show that the continuation of benefits will accomplish rehabilitation.

D. Benefits are paid in addition to any other indemnity owed.

IX. CAREER VOCATIONAL TRAINING AND EDUCATION PROGRAM – § 85.70

A. If an employee sustains a shoulder injury and cannot return to gainful employment, a vocational expert is required to evaluate whether the employee would benefits from vocational training or an education program offered through a surrounding community college.

   1. If it is determined that the employee would benefit from this training, the employee will be referred to a nearby community college for enrollment in a program that will result in (a minimum) of an associate degree or certificate program which would allow the employee to return to the work force.
   2. The employee has six months from the date of the referral to enroll in this program; otherwise, they will lose their eligibility to participate.
   3. The employee is entitled to financial support from the employer and/or insurance provider, not to exceed $15,000.00 for tuition, fees and supplies.
   4. The employer and/or insurance carrier may request progress reports each semester to assure the employee has a passing grade and regularly attends.
   5. If the employee is not complying with these requirements, eligibility for participation can be terminated.

X. AVERAGE WEEKLY WAGE/COMPENSATION RATE – § 85.36 & § 85.37

A. Average Weekly Wage (AKA Gross Weekly Earnings)
   1. The weekly earnings of the employee are computed by averaging the total spendable earnings in the thirteen weeks prior to the injury. § 85.36. However:
      a. If the employee's wage is reduced because of reasons personal to the employee, i.e. sickness or vacation, the employee's weekly earnings shall be based on the amount the employee would have earned.
      b. If a week "does not fairly reflect the employee's customary earnings" the week shall be replaced by the closest previous week which fairly represent the employee's earnings.
      c. The overtime rate is not included. Overtime hours are computed at straight time.
         i. Exception for part time employees.
      d. Irregular bonuses, expense allowances, and employer's contributions to benefit plans are not included in the average weekly wage.
   2. Special Cases –
      a. *Part-time employees*: If the employee earns less than the usual weekly earnings of a regular full-time adult laborer in the same industry and locality, then the weekly earnings are 1/50th of the total earnings which the employee has earned in the prior 12 calendar months, including premium pay, shift differential, and overtime pay from all employment.
      b. *Employees with indeterminate earnings*: In situations where the employee's earnings can not be determined, the gross weekly earnings are based on the usual earnings for similar services rendered by paid employees.
      c. *Volunteer Firefighter, EMT, and Reserve Peace Officers*: Any compensation earned by a volunteer firefighter, emergency medical care provider, or reserve peace officer shall be disregarded for purposes of calculating gross weekly earnings in the event of a compensable injury. The gross weekly earnings are calculated from the *greater* of:
         i. The amount the employee would receive if injured in the scope and course of his or her regular job.
         ii. 140% of the state average weekly wage.
      d. *Apprentice or Trainee*: Gross weekly earnings may be augmented if the apprentice or trainee's wages would have increased absent the work-related injury.
      e. *Inmates § 85.59*: Inmates are due the minimum compensation rates under 85.34 in the event of injury or death.
      f. *Elected or Appointed Official*: An elected or appointed official has the option of choosing between:
         i. Their rate of pay as an elected official, or:
         ii. 140% of the state average weekly wage.

3. The employer has an affirmative obligation to produce wage information to the employee following a workers' compensation claim. Failure to produce the information is a simple misdemeanor.

B. Compensation Rate
   1. 80% of the employee's weekly spendable earnings, subject to maximums set by the Division of Workers' Compensation
      a. No calculations are necessary—Consult the charts available at www.iowaworkforce.org/wc to determine the correct rate once weekly spendable earnings, marital status, and number of exemptions have been established.
      b. Charts are updated yearly by Division, consult chart which corresponds to the date of accident.
      c. Rate stays the same through pendency of claim.
   2. Minimum rate shall be the lesser of:
      a. The weekly benefit amount of a person whose gross weekly earnings are 35% of the statewide average weekly wage (calculated and published by the Division) OR
      b. The spendable weekly earnings of the employee

XI. DISABILITY BENEFITS - § 85.33, 85.34

A. Temporary Total Disability (TTD)
   1. Payable when employee is unable to return to gainful employment because of a work related injury which *will not* result in permanent disability.
      a. Terminated when:
         a. The employee returns to work, or:
         b. There is a finding that the employee is medically capable of returning to employment substantially similar to the employment in which the employee was engaged at the time of the injury.
   2. Temporary total disability payment shall start on the fourth day of disability. Benefits must be paid for those days if the employee is disabled for more than 14 days. § 85.32.
   3. Can be owed for scheduled as well as whole body injuries.
   4. If the employer offers the employee suitable work and the employee refuses to accept the suitable work offered by the employer, the employee shall not be compensated with temporary total disability during the period of the refusal.

B. Temporary Partial Disability (TPD) § 85.33(2)
   1. Compensation is 2/3rds of the difference between the employee's weekly earnings at the time of the injury and the employee's actual gross weekly income during the period of temporary disability. § 85.33(4)
   2. Payable when the employee is temporarily disabled, but is able to work light duty for the employer or an alternative employer.

3. If the employer offers the employee suitable work and the employee refuses to accept the suitable work offered by the employer, the employee shall not be compensated with temporary partial disability during the period of the refusal.

C. Permanent Partial Disability (PPD) – § 85.34
    1. Scheduled Member Injuries – "Loss of Use"
        a. Payable when the employee sustains a permanent impairment causally related to an injury in the scope and course of employment.
        b. Compensation for permanent partial disability shall begin when it is medically indicated that the employee has reached maximum medical improvement form the injury or percentage of permanent impairment can be determined by use of the AMA Guidelines.
        c. Based upon a statutory schedule codified in § 85.34
            i. Iowa subscribes to the 5th Edition of the AMA Guidelines for permanent impairment, but adherence to these guidelines is not compulsory.
        d. The amount payable for specific injuries contemplates both the impairment and payment for the reduced capacity to perform labor.
    2. Body as a Whole Injuries – "Loss of Earning Capacity"
        a. Compensation is 80% of employee's weekly spendable earnings up to the statutory maximum, multiplied by the industrial disability rating, multiplied by 500 weeks.
        b. Applies to all injuries causing permanent impairment not specifically mentioned in § 85.34
        c. Industrial Disability (claimant's lost earning capacity) is determined by considering:
            i. The employee's age, education, qualifications, and experience;
            ii. Employee's inability, because of the injury, to engage in employment for which he or she is fitted;
                (1). The inability can be caused by a physical or emotional condition.
            iii. Failure of the employer to provide employment after an employee suffers an injury;
            iv. A change in the employee's status at his or her employment following a return to work;
            v. Employee's mitigation of his or her industrial disability.
    3. If an overpayment of temporary total or healing period benefits occurs, a credit may be given against permanent disability benefits.

D. Permanent Total Disability – (PTD) § 85.34
    1. Where employee has lost access to the labor market based on personal factors coupled with the employee's permanent physical condition caused by the work-related injury, and the employer has failed to carry its burden of producing evidence of available suitable employment.
    2. The benefits are paid for the employee's life.

E. Healing Period of Permanent Disabilities § 85.34
    1. Compensation will start when employee is unable to return to gainful employment because of a work related injury which will result in permanent disability.
        a. Benefits terminate when:
            i. The employee returns to work, or:
            ii. It is medically indicated that significant improvement from the injury is not anticipated or;
            iii. The employee is medically capable of returning to employment substantially similar to the employment in which the employee was engaged at the time of the injury, or;
        b. To terminate healing period benefits, the employer/carrier must provide the employee 30 days written notice ("Auxier letter") prior to the termination of benefits, and inform the claimant he has the right to file a claim with the Division unless the employee's healing period terminates by a return to work. Failure to provide proper notice of termination, delay or denial of benefits will result in penalties. *Auxier v. Woodward State Hospital-School*, 266 N.W.2d 139 (Iowa 1978).
    2. If an overpayment of temporary total or healing period benefits occurs, a credit may be given against permanent disability benefits.
    3. If the employer offers the employee suitable work and the employee refuses to accept the suitable work offered by the employer, the employee shall not be compensated with healing period benefits during the period of the refusal.

F. Interest
    1. Interest should be volunteered when any late payments are made. Penalties will not be assessed on late interest payments, but interest will continue to accrue
    2. If delay in payment of benefits is due to neglect of the claimant, interest is not payable
    3. Interest is calculated in a 3 step process as follows:
        a. Step 1:
            i. Locate the number of weeks during which benefits are payable in column A of the 10% interest table contained in the Division's manual for the year corresponding to the late payments
            ii. Locate the interest multiplier from that line from the same table in column B
            iii. Multiple the weekly benefit amount by the interest multiplier to determine interest payable
        b. Step 2:
            i. Compute the interest from the end of the period during which benefits are payable until date benefits are actually paid using the following formula: I = P x R x T

(1). I = Interest
(2). P = principal (the total # of weeks/days to 3 decimal points of compensation due x compensation rate)
(3). R = rate of interest (10%)
(4). T = time (# of weeks from end of period during which benefits are payable until date of payment, divided by 52)

c. Step 3:
   i. Add result from Step 1 to result from Step 2

G. Offering Temporary, Light Duty Work
   1. The employer must communicate the offer of a light duty position in writing. If the employee refuses the position, the employee must communicate the refusal in writing including the reason for the refusal.
   2. If an employee was traveling for 50 percent or more of their work time prior to their injury, light duty positions at the employer's principal place of business are acceptable, accommodated positions.

H. Duplicate Benefits
   1. An employee may not receive both permanent partial disability benefits at the same time the employee is receiving permanent total disability benefits. On the date the employee begins receiving permanent total disability benefits, the permanent partial benefits will terminate.

XII. DEATH BENEFITS - § 85.31

A. Reasonable burial expenses are payable, not to exceed 12 times the statewide average weekly wage paid employees as determined and published by the Division in effect at the time of death.
B. Death benefits are payable to the dependents who are wholly dependent on the earnings of the employee for support at the time of the injury.
C. A dependent spouse shall receive weekly payments, commencing from the date of death, for the life of the dependent spouse, provided that that the spouse does not remarry. In the event of remarriage, two years of death benefits shall be paid to the surviving spouse in a lump sum if there are no children entitled to benefits.
D. Dependent children shall receive a proportional share of weekly benefits commencing from the date of death until the age of 18, unless dependency extends beyond the age of 18 if actual dependency continues. Full-time enrollment in any accredited educational institution shall be a conclusive showing of actual dependency.
E. Dependent children who are physically or mentally incapacitated from earning at the time of the injury causing death shall receive a proportional share of weekly benefits for life, or until they shall cease to be physically or mentally incapacitated from earning.

XIII. DEFENSES

A. Statutory:

1. *Willful injury/Intoxication.* § 85.16. No compensation under this chapter shall be allowed for an injury caused:
    a. By the employee's willful intent to injure the employee's self or to willfully injure another;
    b. By the employee's intoxication, which did not arise out of and in the course of employment but which was due to the effects of alcohol or another narcotic, depressant, stimulant, hallucinogenic, or hypnotic drug not prescribed by an authorized medical practitioner, if the intoxication was a substantial factor in causing the injury.
    c. By the willful act of a third party directed against the employee for reasons personal to such employee.
2. *Statute of Limitations.* § 86.13. An action must be filed:
    a. Within two years of the occurrence of the accident or injury under the Workers' Compensation Act, or
    b. Within three years of the date of last payment if weekly benefits are paid pursuant to § 86.13.
3. Notice. Notice of an injury is requited within 90 days from the date of the "occurrence" of the injury.

XIV. PENALTIES

A. In order to deny any benefits due and owing under the Iowa Workers' Compensation Act, the employer must have a reasonable or probable cause or excuse for the delay, denial, or termination of payments.

B. The employer must show the following:
    1. The employer or insurance carrier conducted an investigation and evaluation of whether benefits were due and owing to the employee;
    2. The results of the investigation or evaluation were the contemporaneous basis of the denial, delay, or termination of benefits;
    3. The employer or insurance carrier contemporaneously communicated the basis for the denial, delay, or termination of benefits to the employee.

C. The employer or insurance carrier must provide the employee thirty days notice stating the reason for the termination of benefits and advising the employee of their right to file a claim with the Commission.

D. If the Commission finds that the basis for the denial was unreasonable or without probable cause, a penalty, up to 50% of the benefits that were denied, delayed, or terminated.

E. Practical tips regarding penalties:
    1. The employer/insurer should assume that if the initial weekly payment will not be made when it is due, the facts of the investigation and delay should be communicated in writing to the employee no later than the date the initial payment would otherwise be due

2. At the outset of the claim, communicate with the employee that the claim report is acknowledged and an investigation is required. Also inform employee that because it takes time to obtain relevant information, weekly benefits may be delayed until the investigation is complete.
3. Communication with the employee should indicate that employee's cooperation is required in the investigation.
4. The statute does not require that communication to the employee be in writing, but it be from an evidentiary standpoint.
5. Investigate promptly. This may include:
    a. Obtain recorded statement as soon as possible
    b. Write for medical records as soon as a list of providers and Patient's Authorization are available
    c. Medical evaluations/testing should be scheduled as soon as available.
6. If there is a delay in the investigation (i.e. slow response from medical providers), this should be communicated to the employee in writing
7. If employee fails or refuses to cooperate in the investigation the failure/refusal should be communicated to employee in writing explaining the delay or refusal is preventing the investigation and delaying payment of benefits.
8. If the investigation proves the claim is valid this should be communicated to the employee in writing and all accrued benefits plus interest should be paid.
9. If the investigation reveals information that supports a denial of the claim, this should be communicated to the claimant in writing with explanation as to the reason and basis for denial.
10. The duty to investigate continues beyond the initial determination and all results and consequences of the investigation should be communicated in writing to the employee.
11. Once the claim is referred to counsel be sure to provide all of the above communication to defense counsel in the event the claim becomes litigated.

XV. SETTLEMENTS - § 85.35

A. Types of Settlements:
    1. Agreement for Settlement
        a. Parties may enter into an agreement as to the amount and extent of compensation due and file with the Commissioner.
        b. This type of settlement will not end future rights or medical benefits
    2. Compromise Settlement (AKA Special Case Settlement or Closed File)
        a. When there is a dispute as to whether or not the employee is entitled to benefits, parties may enter into a compromise settlement
            i. There must be at least one issue in dispute and it must be clear what the dispute is. Nature and extent of the injury are generally not sufficient without supporting medical to clearly describe the dispute.
        b. This type of settlement ends the employee's future rights to any benefits

B. General Settlement Information:

1. Full Commutation:
    a. Lump sum payment of all remaining future benefits
    b. Must be at least 10 weeks of benefits remaining from date of the end of the healing period or temporary total disability period. If less than 10 weeks are remaining full commutation will not be allowed.
    c. Once approved this will end all of employee's future rights to any additional benefits including medical
    d. To be approved, parties must show the employee has a specific need and the lump sum is in the best interest
        i. Pro se employees must complete a Claimant's Statement expressing that need
2. Partial Commutation:
    a. Lump sum payment of a portion of the remaining benefits
    b. Establishes the employee's entitlement to disability benefits but it does not end future rights.
3. Settlement language may not include "any and all injuries" or "other states or jurisdictions."

XVI. PROCEDURE

A. Filing of Original Notice and Petition or Petition for Alternate Care begins the litigation process
    1. Answer or other responsive motion must be filed within 20 days
    2. Discovery may commence via Interrogatories, Request for Production, Request for Admission, Depositions
    3. Notice of Service of Medical Records (NOS) served on opposing party on a continuing basis
        a. NOS of all medical records in a party's possession must be served within 20 days of filing an Answer and within 10 days of receipt of records for the remainder of the claim. Failure to properly serve records could prevent admission of the records into evidence.
    4. Alternative Dispute Resolution is encouraged through the Division or through private mediation
    5. Hearings:
        a. If claim has not been resolved through settlement a hearing will be held and a Deputy Commissioner will determine Claimant's rights and issue an award.
        b. All evidence must be submitted at the time of the hearing – the record will be closed at the conclusion of the hearing.
        c. Case is left open following a hearing and award for lifetime medical and Review & Reopening for a period of 3 years from the date of the last weekly benefits paid.
        d. Continuances generally are not granted even if a claimant has not reached MMI

e. Appeal to Commissioner must be filed within 20 days of Deputy's decision.
f. Appeal to District Court within 30 days of final agency decision
    i. District Court is bound by the factual determinations made by the Agency unless a different result is required as a matter of law – if the agency decision is "irrational, illogical or wholly unjustifiable."
    ii. If a decision is supported by substantial evidence the decision will not be overturned.
g. Appeal to Iowa Supreme Court within 30 days of the District Court's final judgment

RECENTLY ASKED QUESTIONS IN IOWA
FROM ISSUES ADDRESSED IN RECENT IOWA CASES

Q: When a claimant presents a medical expert opinion as evidence, is it appropriate for the commissioner to discredit the report when the expert was not provided with accurate facts concerning the claimant's job description?

A: Yes. Especially when considering the court also found evidence in the record that the injury was not worked up independently and the claimant experienced persistent symptoms and difficulty with the same claimed body part for a decade before, only stopping two years prior.

In *Mahoney*, Claimant had suffered an earlier injury to her right arm and wrist over a decade prior to her alleged cumulative work injury to the same body parts. At the arbitration level, the deputy considered the opinion of Claimant's medical expert, but found other evidence did not support a finding that Claimant experienced a new work injury. The deputy and commissioner held that the claimant failed to establish a new, permanent injury to her arm, and Claimant's case against the employer and Second Injury Fund was dismissed.

On judicial review, the district court affirmed the commissioner's decision. The court noted the commissioner considered all of the relevant evidence and determined the Claimant had not established a permanent, cumulative injury to her right arm and wrist. The court further stated the commissioner could have concluded Claimant's expert's opinion was not persuasive on the ground that the doctor had been provided with inaccurate facts.

On appeal, the claimant alleged the commissioner improperly disregarded her expert's medical opinion. The Court of Appeals determined there was substantial evidence in the record to support the commissioner's factual findings. Contrary to the claimant's argument, the commissioner did not ignore important and relevant evidence. The commissioner appropriately determined the weight to be given to the evidence in the case, including the Claimant's expert opinion, and found the Claimant did not establish her claim of a cumulative injury.

Mahoney v. Robert Half International and Second Injury Fund of Iowa, No. 20-0868 (Iowa App. June 30, 2021).

Q: Does the commissioner's misinterpretation of a Social Security decision automatically detract from the agency's decision to render a reversal of the ruling?

A: No. The question is whether there is substantial evidence supporting the findings made, not whether the evidence supports a finding different than that of the agency.

In *Snitker*, the claimant suffered a back injury and eventually had a lumbar laminectomy and fusion. She alleged she was permanently and totally disabled as a result of her work injury. However, the deputy found claimant to have suffered industrial disability of forty percent. The commissioner similarly found that Claimant had not demonstrated entitlement to permanent total disability benefits. In support of

this determination, the commissioner noted that Claimant's Social Security Disability application had not been approved. On judicial review, district court affirmed the forty percent industrial disability award.

On appeal, Claimant maintained she was permanently and totally disabled. Claimant argued that the agency's decision was based on an erroneously interpreted Social Security's determination of Claimant's disability. While the court agreed with this position, it found that the agency's misinterpretation of Social Security's decision did not detract from the agency's ultimate finding of forty percent disability. The court further found there was substantial evidence supporting the commissioner's forty-percent industrial disability award rather than total disability and, accordingly, affirmed the agency's decision.

Snitker v. Seabright Insurance Company and Birdnow Enterprises, No. 20-0986 (Iowa App. June 16, 2021).

Q: When the commissioner is faced with contradicting medical evidence from which different conclusions may be drawn, is it appropriate for the district court to reassess the weight of the evidence and reverse the commissioner's decision?

A: No. The commissioner is the fact finder who determines the weight to be given to expert testimony and medical causation presents a question of probability of which absolute certainty is not required to establish. On judicial review, it is not the district court's role to weigh the credibility of the experts before the commissioner.

In *Hildreth*, the claimant sustained a traumatic brain injury while working for Defendants. Approximately two years later, Claimant suffered a stroke that ultimately caused his death. Following his death, Claimant's wife filed a petition seeking death benefits, medical expenses, and costs arising out of Claimant's stroke and passing. Defendants denied the claim, asserting there was no causal connection between Claimant's injury and the stroke which led to his death. Faced with contradicting medical opinions and evidence, the deputy ultimately found in favor of the claimant and awarded death benefits and reimbursement of medical expenses with the commissioner later affirming the deputy's findings. However, on judicial review, the district court reversed the commissioner's holding after excluding one of the expert reports considered by the commissioner. The district court held that without that evidence, there was insufficient evidence in the record to support the commissioner's decision awarding death benefits.

On appeal, the court of appeals found that when, viewed as a whole, substantial evidence existed in the record to support the deputy's findings and commissioner's decision. The court noted it was within the commissioner's discretion to accept the opinion of one expert opinion over the other; and because the commissioner is tasked with weighing the evidence, the court liberally and broadly construes the commissioner's findings to uphold the commissioner's decision. With this holding, the court of appeals reversed the district court's decision and reinstated the commissioner's ruling.

Des Moines Public Schools v. Hildreth, No. 20-0742 (Iowa App. June 16, 2021).

Q: When a Claimant's injury involves not only the muscles of the shoulder, but the muscles of the back, can the injury be found to extend into the body as a whole?

A: Yes. If a Claimant's injury impacts and involves muscles other than that of the shoulder, the injury may be found to be an injury to the body as a whole and entitle the claimant to industrial disability benefits.

In *Bolinger*, the claimant, who had pre-existing left shoulder conditions, sustained an injury to her left shoulder while working for Defendant resulting in a left reverse shoulder replacement. The deputy found that because the case involved more than a rotator cuff surgery, the facts of *Bolinger* were different from those of the *Deng*, *Chavez*, and *Smidt* decisions and awarded Claimant permanent partial disability benefits resulting from an injury to the body as a whole. The deputy's finding was only supported by one expert, Dr. Stoken, who opined Claimant's reverse shoulder replacement involved and impacted the muscles in Claimant's upper back—including, but not limited to, the rhomboids, the serratus and the trapezius muscles. With no opinion or evidence to contradict Dr. Stoken's opinion, and post-surgery physical therapy protocol involving strengthening of the deltoids and the periscapular muscles to aid in the stability of the replaced joint, the deputy found the claimant's injury extended into the body as a whole.

However, since the claimant had returned to work for the employer earning greater earnings than she did at the time of the injury, Claimant's permanent partial disability benefits were statutorily limited to the functional impairment of her injury since she returned to work for the employer at a greater hourly rate than she had earned at the time of her injury.

Bolinger v. Trillium Healthcare Group, LLC, File No. 5060856, Arbitration Decision (June 17, 2021).

Q: Do injuries to the "shoulder" for the purposes of benefits under Iowa Code section 85.34(2)(n) include rotator cuff tears?

A: Yes. The rotator cuff is essential to the function of the glenohumeral joint or shoulder joint, and injuries that impair the function of the shoulder are properly considered scheduled-member shoulder injuries.

In *Deng*, Claimant sustained a work injury to her labrum and infraspinatus muscle (rotator cuff muscle). Claimant argued that because her injury was to the proximal side of her shoulder, it was to be classified as an unscheduled injury to the body as a whole. Defendants argued that Claimant's injury was to her shoulder and was therefore limited to a scheduled member compensation analysis under the 2017 amendments.

A deputy's arbitration decision found Claimant to have sustained an unscheduled injury to the body as a whole. The commissioner reversed this decision on appeal, and instead found Claimant's injury was a scheduled-member "shoulder" injury limited to a functional impairment analysis. On judicial review, the court found that the claimant's shoulder function, namely her ability to articulate her arm, was impaired as a result of the injury, and as such, substantial evidence existed to support the commissioner's finding that Claimant's rotator cuff injury was properly considered a shoulder injury.

Deng v. Farmland Food, Inc., File No. 5061883, Ruling on Judicial Review (Iowa Dist. Ct. May 21, 2021.)

Q: Does an exhaustive review of medical records which show "numerous notations" of symptom magnification, embellishment, and pain and weakness inconsistencies support a take-nothing decision by the agency and district court?

A: Yes. When the commissioner carefully reviews all medical records provided in a case prior to issuing a decision, and the reviewing court finds substantial evidence supports the commissioner's finding, the ruling will be upheld.

In *Rizvic*, Claimant sustained an electrocution injury and alleged various permanent injuries as a result. In an arbitration decision, a deputy awarded Claimant permanent total disability benefits, alternate medical care, and medical-expense reimbursement. On appeal, the commissioner reversed the arbitration decision in its entirety upon finding Claimant was not a credible witness and did not sustain any permanent disability as a result of his injury. On judicial review, the district court affirmed the commissioner's Claimant-takes-nothing ruling.

Claimant appealed this decision to the court of appeals who agreed Claimant had failed to established causation. The court emphasized that the commissioner is the fact-finder who is tasked with determining the weight given to each expert's testimony. It noted the commissioner mentioned "numerous notations" of symptom magnification or embellishment along with pain and weakness inconsistencies following a careful review of all provided records. The district court similarly conducted an exhaustive examination of all medical records prior to finding substantial evidence supported the commissioner's ruling that Claimant's medical issues were not work related.

In concurrence with the district court, the court of appeals found substantial evidence supported the commissioner's decision and affirmed the denial of Claimant's workers' compensation disability claim.

Rizvic v. Titan Tire Corporation, No. 20-1133 (Iowa Ct. App. May 12, 2021).

Q: If an incident of physical contact occurs at work and an employee subsequently fills out a report with their employer explaining the incident, but fails to claim any injury or mention any pain, does that report put the employer on notice of an injury?

A: Yes. When an employee completes a written report of an incident of physical contact at work, the employer is put on fair notice of a work injury and the possibility of a workers' compensation claim. There is no requirement for notice of the precise nature of the employee's injury.

In *Dickerson*, Defendants asserted an affirmative notice defense, arguing that because Claimant failed to provide notice of his injury within ninety days, he was barred from making a claim for workers' compensation benefits. Defendants noted that while Claimant did fill out a "Near Miss Report," the statement lacked any claim that Claimant was injured.

The commissioner, district court, and court of appeals rejected this argument and found that a written report, regardless of the title, put Defendants on notice that an incident occurred and gave them the opportunity to investigate. The court ultimately held that when an incident happens at work and the employee determines it warrants the completion and submission of a report, that report fairly puts the employer on notice that the employee was likely in some degree of pain to qualify as an injury under Iowa law.

John Deere Davenport Works v. Dickerson, No. 20-0658 (Iowa Ct. App. April 14, 2021).

Q: If a claimant's employment ends for a reason other than their alleged work injury, can they still be found to meet the criteria for a second healing period entitling them to additional healing period benefits?

A: Yes. An unsuccessful, temporary return to work does not bar a claimant from an award of additional healing-period benefits.

In *Roberts*, a deputy found Claimant was entitled to additional healing benefits and awarded thirty percent industrial disability. The deputy also found Defendant to be responsible for certain prescription medications. While the commissioner affirmed and adopted the deputy's additional healing and industrial disability benefits award, he did not find Defendants were responsible for the prescribed medications in question. On judicial review, the district court affirmed the commissioner's decision on all three issues. On appeal, Defendants challenged both the Claimant's entitlement to additional healing-period benefits and the extent of industrial disability.

Defendants argued that because Claimant's employment did not end due to his injury, he did not meet the criteria for an additional-healing period. However, citing prior decisions from the Iowa Supreme Court, the court of appeals noted "some attempts to return to work are unsuccessful and temporary" and went on to conclude "the legislature did not intend to deny an employee additional healing-period benefits because of an unsuccessful return to work." With this holding, and the fact that the Claimant (1) had not returned to work, (2) was not medically capable of returning to substantially similar work, and (3) was not at MMI following the end of his employment with Defendants, the award of healing-period benefits was affirmed. The court of appeals further found substantial evidence supported the industrial disability determination made by the commissioner, and the district court's decision was affirmed in its entirety.

Annett Holdings, Inc. v. Roberts, No. 20-0155 (Iowa Ct. App. April 14, 2021).

Q: If parties engage in negotiations for a partial commutation of benefits but the claimant dies before accepting the final terms of the agreement, is there an enforceable settlement?

A: No. When a claimant is still in control of taking or leaving a settlement offer at the time of their death, there is no meeting of minds and, consequently, no contract to enforce.

In *Estate of Ed Albaugh*, a settlement of Claimant's petition for partial commutation of workers' compensation benefits had been reached before he died. When Claimant's

estate asked the district court to enforce the settlement, it found "that the parties engaged in settlement negotiations that did not result in an agreement on its final terms" and, therefore, there was no agreement for the court to enforce.

On appeal, the court of appeals agreed with the district court's decision and found there was no agreement to enforce. At the time of Claimant's death, the interest rate at which the lump sum benefits would be paid was still in dispute. Further, the claimant had not yet agreed to the settlement. Therefore, while an offer had been made, there was nothing in the record that could have been construed as an acceptance to that offer. No mutual assent means no contract to enforce. With this holding, the district court's ruling on summary judgment finding in favor of Defendants was affirmed.

Estate of Ed Albaugh v. UPS Freight, No. 20-0070 (Iowa Ct. App. April 14, 2021).

Q: When there are competing opinions from medical experts concerning injuries that are complex and difficult to diagnosis such as concussions and traumatic brain injuries, can the opinions from treating physicians be given more weight than those from experts who performed a one-time evaluation?

A: Yes. When the medical community has widely divergent opinions on an injury due to its complexity, the court may have difficulty affording any significant weight to the opinions of expert reports who have never observed the Claimant's condition, or only did so on a one-time or limited basis.

In *Baker*, Claimant sustained a stipulated work injury which he alleged resulted in permanent head and mental health injuries. A deputy commissioner found Claimant failed to carry his burden of proof to establish his stipulated work injury caused permanent disability. However, this arbitration decision was reversed by the commissioner on appeal.

While the commissioner noted the question of causal connection is essentially within the domain of expert testimony, there were conflicting medical opinions as to the cause of Claimant's current conditions. Claimant relied upon the medical opinions of his authorized treating physiatrist, psychiatrist, neurologist, and optometrist. On the other hand, Defendants relied upon five independent medical opinions. Three of Defendants experts never physically examined or saw Claimant. The other two experts conducted a one-time evaluation for litigation purposes.

The commissioner noted it was "abundantly clear" that the medical community has widely divergent opinions on concussions and traumatic brain injuries as such injuries are often complex and can be difficult to diagnose. For these reasons, the commissioner found it was difficult to afford any significant weight to opinions from experts who never observed Claimant's condition. Similarly, the commissioner found it was difficult to afford any significant weight to opinions from experts who evaluated Claimant on a one-time basis, when comparing the opinions to those of three authorized treating physicians who regularly saw Claimant.

Baker vs. MSC Industrial Direct Co. and Ace American Insurance Co., File No. 5063687, Appeal Decision (March 17, 2021).

Q: Can a claimant's voluntary termination from an employer trigger entitlement to industrial disability.

A: Yes. When an employee does not return to work with the same employer that he/she was working for at the time of the injury, that employee is allowed industrial disability for a whole-body injury.

In *Martinez*, claimant alleged injuries to his bilateral lower extremities, right wrist, head and back. Claimant returned to work for the employer for several months before voluntarily leaving employer and enrolling in an apprenticeship program. Even though claimant was earning greater wages at the time of the Arbitration hearing than he was when he was injured, his leave from the employer removed him from functional impairment analysis and triggered an entitlement to benefits under the industrial disability analysis. Specifically, the workers' compensation commissioner issued an appeal decision stating that when an employee does not return to work with the same employer that he/she was working for at the time of the injury, that employee is allowed industrial disability for a whole-body injury. In the event employee is with the same employer, which he/she was with at the time of the injury, and that employer offers employee the same or higher wage level work which employee accepts than there is a limitation on employee's allowance of an industrial disability. However, if the employee is offered the work and declines it, he/she is allowed industrial disability under the law.

Zachary Martinez v. Pavlicj Inc and National Interstate Insurance, File No: 5063900, Appeal Decision July 30, 2020.

Q: Will an award for partial commutation be upheld when supported by a claimant's testimony concerning his/her plans to invest and the approval of the claimant's financial adviser?

A: Yes. Whether the award of a partial commutation is in the best interests of a claimant, is a fact-based determination. The court will consider multiple factors in their determination of whether a partial commutation is appropriate.

In *United Fire and Casualty v. Hessenius*, claimant was awarded permanent total disability benefits resulting from a work-related shoulder injury in the amount of $1,300 per week. Following claimant's petition for partial commutation, the deputy awarded $100,000. The commissioner than reversed and awarded a partial commutation of over $1 million and defendants appealed asserting the commissioner's decision was not supported by substantial evidence, specifically that claimant did not demonstrate how he would make up for the stream of income lost due to the partial commutation.

A claimant seeking commutation of future workers' compensation benefits "to a present worth lump sum payment" must prove certain conditions to the commissioner, including "that such commutation will be for the best interest of the claimant. To establish that a commutation of future workers' compensation benefits is appropriate, the Supreme Court has establish the following factors: (1) the worker's age, education, mental and physical condition, and actual life expectancy; (2) the worker's family circumstances, living arrangements, and responsibilities to dependents; (3) the worker's financial condition, including all sources of income, debts and living

expenses; (4) the reasonableness of the worker's plan for investing the lump sum proceeds and the worker's ability to manage invested funds or arrange for management by others.

Here, the Court of Appeals noted claimant testified that he planned to invest the amounts very conservatively to provide a stream of income and claimant's financial advisor was in full support of the investment plan. Based on these facts, the Court of Appeals found there was substantial evidence supporting the commissioner's award of a partial commutation of over $1 million.

United Fire & Cas. Co. v. Hessenius, No. 19-1929, 2020 WL 7385283 (Iowa Ct. App. Dec. 16, 2020).

Q: ***When two insurance carriers provided coverage for the same employer and a claimant sustains a compensable injury but has ongoing symptoms after being placed at MMI, do subsequent minor incidents or aggrvations constitute new injuries?***

A: No. Claimant's ongoing symptoms when recurrent in nature, would be considered a continunation of the original injury and not separate and distinct subsequent injuries or aggravations. The insurer providing coverage at the time of the original injury would be responsible for all benefits owed as a result of the original loss.

In *Wurtzel*, Claimant filed three Petitions alleging three different dates of injury against the employer and two separate insurers; Commerce and Industry and Am Guard, due to a change in the employer's insurance carrier. Commerce and Industry had accepted compensability for the first date of injury and paid benefits on the claim. In between the first and second alleged injuries, the employer changed insurance carriers, and Am Guard provided coverage during the period of time Claimant allegedly sustained the second and third injuries. However, due to the Claimant's ongoing symptoms following the first injury, Am Guard denied the second and third claimed injuries and argued that claimant's ongoing symptoms, disability and medical treatment were attributable solely to the first date of injury, and thus the responsibility of Commerce & Industry. In the claim, the deputy commissioner relied on the opinions of two of Claimant's treating and evaluating physicians who both opined that the claimant's ongoing symptoms were attributable to the first date of injury. Further, Claimant and his wife both testified that the subsequent dates of injury were continuations of his original symptoms, and not new injuries. For these reasons, it was found that the claimant's ongoing symptoms were recurrent in nature and related to the original date of injury as opposed to separate and distinct subsequent injuries or aggravations. Commerce & Industry was found responsible for all consequences that naturally and proximately flowed from the original date of injury and ordered to pay the entirety of the claimant's award for benefits.

Cory Wurtzel, Claimant, No. FILE NUMBERS: 506013, 2021 WL 150665, at *1 (Jan. 11, 2021).

Q: Can a claimant, who received disability benefits for a traumatic injury later recover disability benefits on a separate cumulative injury claim if the cumulative injury is based solely on aggravation of the earlier traumatic injury?

A: No. In order to obtain additional benefits for the cumulative injury the alleged cumulative injury must be distinct and discrete and not merely an aggravation over time of the original injury.

In Gumm, claimant sustained an injury in 2008 which she received permanent partial disability benefits for. The last monthly benefit payment occurred in 2010. As a result of her ankle condition worsening, she made a claim in February of 2014, almost 4 years after her benefits stopped.

When a claimant has received disability benefits for a prior compensable injury, that claimant is limited to the review-reopening remedy for additional disability benefits unless he/she can prove they have suffered another injury. If the subsequent injury is a cumulative injury, it must be a distinct and discrete injury, not merely the aggravation of the prior injury due to regular work activities. Here, claimant did not file within that time frame and thus could only recover by arguing that the injury was a cumulative injury. Defendants disagreed alleging the claimant's complaints were an aggravation of her prior injury.

Here, the Supreme Court found there was sufficient evidence to sustain the commissioner's finding that claimant did not suffer a distinct and discrete cumulative injury but merely the aggravation over time of her original 2008 injury. Evidence supported the commissioner's view that claimant's post-2008 difficulties were entirely sequelae to her original injury thus dismissing her claim.

Gumm v. Easter Seal Soc'y of Iowa, Inc., 943 N.W.2d 23 (Iowa 2020).

Notes Pages

Notes Pages

Notes Pages

KANSAS WORKERS' COMPENSATION

Applies to injuries occurring on or after May 15, 2011.

I. JURISDICTION - K.S.A. 44-506

A. Act will apply if:

1. Accident occurs in Kansas.
2. Contract of employment was made within Kansas, unless the contract specifically provides otherwise.
3. Employee's principal place of employment is Kansas.

II. ACCIDENTS

A. Traumatic Accidental Injury

1. "Undesigned, sudden, and unexpected traumatic event, usually of an afflictive or unfortunate nature and often, but not necessarily, accompanied by a manifestation of force."
2. "An accident shall be identifiable by time and place of occurrence, produce at the time symptoms of an injury, and occur during a single work shift."
3. "The accident must be the prevailing factor in causing the injury."
4. Deemed to arise out of employment only if:
    a. There is a causal connection between the conditions under which the work is required to be performed and the resulting accident; and
    b. The accident is the prevailing factor causing the injury, medical condition, and resulting disability or impairment.

B. Repetitive Use, Cumulative Traumas or Microtraumas– K.S.A. 44-508(e)

1. "The repetitive nature of injury must be demonstrated by diagnostic or clinical tests."
2. "The repetitive trauma must be the prevailing factor in causing the injury."
3. Date of accident shall be the earliest of:
    a. Date the employee is taken off work by a physician due to the diagnosed repetitive trauma;
    b. Date the employee is placed on modified or restricted duty by a physician due to the diagnosed repetitive trauma;
    c. Date the employee is advised by a physician that the condition is work related; OR
    d. Last day worked, if the employee no longer works for the employer.

e. In no case shall the date of accident be later than the last date worked.

4. Deemed to arise out of employment only if:
    a. Employment exposed the worker to an increased risk or hazard which the worker would not have been exposed in normal non-employment life;
    b. The increased risk or hazard to which the employment exposed the worker is the prevailing factor in causing the repetitive trauma; and
    c. The repetitive trauma is the prevailing factor in causing both the medical condition and resulting disability or impairment.

C. Prevailing Factor
1. Primary factor in relation to any other factor.
2. Judge considers all relevant evidence submitted by the parties.

D. Exclusions
1. Triggering/precipitating factors
2. Aggravations, accelerations, exacerbations
3. Pre-existing condition rendered symptomatic
4. Natural aging process or normal activities of daily living
5. Neutral risks, including direct or indirect results of idiopathic causes
6. Personal risks

III. NOTICE OF ACCIDENT - K.S.A. 44-520

A. Notice requirements depend on the date of accident.
B. For accidents after April 25, 2013:
1. Notice must be given by the earliest of the following days:
    a. 20 calendar days from the date of accident or injury by repetitive trauma**;**
    b. 20 calendar days from the date the employee seeks medical treatment for the injury; or
    c. 10 calendar days from the employee's last day of actual work for the employer.

C. For accidents between May 15, 2011, and April 25, 2013:
1. Notice must be given by the earliest of the following days:
    a. 30 calendar days from the date of accident or injury by repetitive trauma**;**
    b. 20 calendar days from the date the employee seeks medical treatment for the injury; or

c. 20 calendar days from the employee's last day of actual work for the employer.

D. For accidents before May 15, 2011:
1. Notice must be given within 10 days of the accident unless the employer had actual knowledge of the accident.
2. If an employee does not provide notice within 10 days, his claim will not be barred if his failure to provide notice was due to just cause, provided that:
    a. Notice was given within 75 days; or
    b. The employer had actual knowledge of the accident; or
    c. The employer was unavailable to receive notice; or
    d. The employee was physically unable to give such notice.

E. May be oral or in writing
1. "Where notice is provided orally, if the employer has designated an individual or department to whom notice must be given and such designation has been communicated in writing to the employee, notice to any other individual or department shall be insufficient under this section. If the employer has not designated an individual or department to whom notice must be given, notice must be provided to a supervisor or manager."
2. "Where notice is provided in writing, notice must be sent to a supervisor or manager at the employee's principal location of employment." The burden is on the employee to prove that such notice was actually received by the employer.

F. Notice shall include the time, date, place, person injured and particulars of the injury and it must be apparent the employee is claiming benefits or suffered a work-related injury.

G. Notice requirement is waived if the employee proves that
1. the employer or employer's duly authorized agent had actual knowledge of the injury;
2. the employer or employer's duly authorized agent was unavailable to receive such notice within the applicable period; or
3. the employee was physically unable to give such notice.

IV. REPORT OF ACCIDENT – K.S.A. 44-557

A. Employer / carrier must file with the Division of Workers' Compensation within 28 days of obtaining knowledge of any accident that requires an employee to miss more than the remainder of the shift in which the injury occurred.
1. Civil penalties are possible for failure to file.
2. Failure to file within 28 days extends the statute of limitations from 200-days to one year from the date the period begins to run.

3. Accident report cannot be used as evidence.

V. APPLICATION FOR HEARING- K.S.A. 44-534

A. The employee must file an application for hearing by the later of:
   1. 3 years after the date of accident; or
   2. 2 years after the last payment of compensation.

B. Once Application for Hearing is filed, claim must proceed to hearing or award within three years or be subject to dismissal with prejudice – K.S.A. 44-523(f)

VI. MEDICAL TREATMENT

A. K.S.A. 44-510h

1. Employer has the right to select the treating physician.
2. Employee has $500 unauthorized medical allowance for treatment.
3. Rebuttable presumption that employer's obligation to provide medical treatment terminates upon the employee reaching maximum medical improvement.
4. Medical treatment does not include home exercise programs or over-the-counter medications.

B. K.S.A. 44-510k

1. After an award, any party can request a hearing for the furnishing, termination or modification of medical treatment.
2. ALJ must make a finding that it is more probably true than not that the injury is the prevailing factor in the need for future medical care
3. If the claimant has not received medical treatment (excluding home exercise programs or over-the-counter medications) from an authorized health care provider within two years from the date of the award or the date the claimant last received medical treatment from an authorized health care provider, there is a rebuttable presumption no further medical care is needed.

C. K.S.A. 44-515

1. All benefits suspended if employee refuses to submit to exam at employer's request.
2. Employee may request that a report from any examination be delivered within a reasonable amount of time (no longer 15 day requirement).

VII. AVERAGE WEEKLY WAGE – K.S.A. 44-511

A. Add wages earned during the 26 weeks prior to the accident and divide by the number of weeks worked during that period. No longer a difference between full-time and part-time employees.

B. Wages = Money + Additional compensation

1. Money: gross remuneration, including bonuses and gratuities.
2. Additional Compensation: only considered if and when discontinued
    i. Board and lodging if furnished by the employer
    ii. Employer paid life insurance, disability insurance, health and accident insurance
    iii. Employer contributions to pension or profit sharing plan.

C. Examples

1. Example One
    a. 26 weeks worked - $10,400 earned
    b. No additional compensation discontinued
    c. Average weekly wage = $400
2. Example Two
    a. 26 weeks worked - $10,400 earned
    b. Additional compensation discontinued following injury
        i. Health insurance-$200 per week.
        ii. Pension contribution-$150 per week.
    c. Average weekly wage - $750

VIII. TEMPORARY BENEFITS – K.S.A. 44-510c(b)

A. Temporary Total Disability

1. Two-thirds of Average Weekly Wage (AWW) from above, subject to statutory maximum determined by date of injury
2. Seven-day waiting period.

    *No temporary total disability for first week unless off three consecutive weeks.
3. Exists when the employee is “completely and temporarily incapable of engaging in any type of substantial gainful employment.”
4. Treating physician’s opinion regarding ability to work is presumed to be determinative.
5. employee is entitled to temporary total disability benefits if employer cannot accommodate temporary restrictions of the authorized treating physician.

6. No temporary total disability benefits if the employee is receiving unemployment benefits.
7. Insurer or self-insured employer MUST provide statutorily mandated warning notice on or with the first check for temporary total disability benefits.

B. Temporary Partial Disability
1. Two-thirds of the difference between Average Weekly Wage pre-accident and claimant's actual post-accident weekly wage up to statutory maximum.
2. available for scheduled and non-scheduled injuries

C. Termination of Benefits
1. Maximum medical improvement
2. Return to any type of substantial and gainful employment
3. Employee refuses accommodated work within the temporary restrictions imposed by the authorized treating physician
4. Employee is terminated for cause or voluntarily resigns following a compensable injury, if the employer could have accommodated the temporary restrictions imposed by the authorized treating physician but for the employee's separation from employment.

IX. PRELIMINARY HEARINGS – K.S.A. 44-534a

A. After filing an Application for Hearing pursuant to K.S.A. 44-534, a party may file an Application for Preliminary Hearing.

B. Seven days before filing Application for Preliminary Hearing the applicant must file written NOTICE OF INTENT stating benefits sought.

C. An Administrative Law Judge will be assigned

D. Hearing can be set seven days later. If claim denied at preliminary hearing, failure to proceed to regular hearing within one year and without good faith reason results in dismissal with prejudice.

E. Benefits to Consider at Preliminary Hearing:
1. Medical treatment (including change of physician).
    a. Ongoing or past bills.
2. Temporary total or temporary partial benefits (including rate).
    a. Prospective or past benefits.
3. Medical records and reports are admissible.

4. Witnesses may be necessary.
5. Opportunity for decision on ultimate compensability issues.

F. Preliminary Awards are binding unless overruled at a later Preliminary Hearing or Regular Hearing.

G. Limited right to review by the Appeals Board.
1. "whether the employee suffered an accidental injury, whether the injury arose out of and in the course of the employee's employment, whether notice is given, or whether certain defenses apply"

H. Penalties – K.S.A. 44-512a
1. Award must be paid within 20 days of receipt of statutory demand. Penalties can be $100 per week for late temporary total and $25 per week per medical bill.

I. Dismissal of claim denied at Preliminary Hearing – K.S.A. 44-523(f)
1. Claim dismissed with prejudice, if:
    a. Case does not proceed to Regular Hearing within one year
    b. Employer files application for dismissal
    c. Claimant cannot show good cause for delay
2. Dismissal considered final disposition for fund reimbursement

X. PRE-HEARING SETTLEMENT CONFERENCES – K.S.A. 44-523(d)

A. Must occur before a Regular Hearing can take place.

B. Generally after claimant reaches maximum medical improvement.

C. Court will clear case for Regular Hearing or enter order for appointment of independent physician to determine permanent impairment of function or restrictions.

D. Process varies from Judge to Judge.

E. Issues regarding final award or settlement are considered.

XI. PERMANENT DISABILITY – K.S.A. 44-510e

A. <u>Maximum Awards</u>
1. Functional Impairment Only - $75,000
    a. Cap now applies even if temporary total or temporary partial disability benefits were paid.

b. $75,000 cap does not include temporary total or temporary partial disability benefits paid.

2. Permanent Partial Disability - $130,000
    a. Cap includes temporary total or temporary partial disability benefits paid
3. Permanent Total Disability - $155,000
    a. Cap includes temporary total or temporary partial disability benefits paid
4. Death benefits - $300,000
    a. Includes $1,000 for appointment of conservator, if required.

B. Reduction for Pre-existing Impairments

1. Basis of prior award in Kansas establishes percentage of pre-existing impairment.
2. If no prior award in Kansas, pre-existing impairment established by competent evidence.
3. If pre-existing injury is due to injury sustained for same employer, employer receives a dollar for dollar credit.
4. In all other cases, the employer receives a credit for percentage of pre-existing impairment.

C. Scheduled Injuries

1. Includes loss of and loss of use of scheduled members
2. Combine and rate multiple injuries in single extremity to highest scheduled member actually impaired
3. Formula
    a. (scheduled weeks – weeks TTD paid) x rating % x compensation rate
4. Example
    a. Arm Injury = 210 weeks
    b. TTD paid = 10 weeks
    c. Rating = 10%
    d. Compensation Rate = $546
        i. **(210 weeks – 10 weeks) x 10% = 20 weeks x $546.00 = $10,920.00**

D. Body as a Whole Injuries

1. Presumption is functional impairment
2. Includes loss of or loss of use of: (1) bilateral upper extremities, (2) bilateral lower extremities, or (3) both eyes.
3. Formula

a. (415 weeks – weeks TTD paid in excess of 15 weeks) x rating % x compensation rate

4. Example
    a. TTD paid = 25 weeks
    b. Rating = 15% Body as a Whole
    c. Compensation Rate = $546.00
        i. **(415 weeks – 10 weeks) x 15% = 60.75 weeks x $546.00 = $33,169.50**
5. Work Disability
    a. High end permanent partial disability.
    b. Allows the employee to receive an Award in excess of functional impairment.
    c. Employee eligible if:
        i. Body as a whole injury; and
        ii. The percentage of functional impairment caused by the injury exceeds 7 ½% or the overall functional impairment is equal to or exceeds 10% where there is preexisting functional impairment; and
        iii. Employee sustained a post-injury wage loss of at least 10% which is directly attributable to the work injury.
6. Formula
    a. ((Wage Loss % + Task Loss %) / 2) x (415 weeks – weeks TTD paid in excess of 15 weeks) x compensation rate
        i. **Wage Loss**: "the difference between the average weekly wage the worker was earning at the time of the injury and the average weekly wage the worker is capable of earning after the injury."
            (a) Consider all factors to determine the capability of the worker, including age, education and training, prior experience, availability of jobs, and physical capabilities.
            (b) Legal capacity to enter contract of employment required.
            (c) Refusal of accommodated work within restrictions and at a comparable wage results in presumption of no wage loss
        ii. **Task Loss**: "the percentage to which the employee, in the opinion of a licensed physician, has lost the ability to perform the work tasks that the employee performed in any substantial gainful employment during the five-year period preceding the injury."

(a) Task loss due to pre-existing permanent restrictions not included

7. Example:
    a. TTD paid = 25 weeks
    b. AWW on date of accident = $1,000.00
    c. AWW after accident = $350
    d. Tasks performed during 5 years prior to accident = 25
    e. Tasks capable of performing after the accident = 10
    f. Compensation Rate = $555.00
        i. **(65% wage loss + 60% task loss) / 2 = 62.5% work disability x (415 weeks – 10 weeks) = 253.125 weeks x $555.00 = $140,484.37**
        ii. This would be capped at $130,000.00, and the amount of TTD paid is considered in determining if the maximum has been reached.

E. Permanent Total Disability
1. Employee is completely and permanently incapable of engaging in any type of substantial and gainful employment.
2. Expert evidence is required to prove permanent total disability
3. Can only be permanently and totally disabled once in a lifetime.

F. Death Cases – K.S.A. 44-510b
1. Burial Expenses:
    a. Employer shall pay the reasonable expense of burial not exceeding $10,000.00 (increase from previous maximum of $5,000.00).
2. Initial Lump sum payment of $60,000.00 to surviving legal spouse or a wholly dependent child or children or both (increase from previous amount of $40,000.00).
3. Weekly benefits thereafter: 50% to surviving spouse – 50% to surviving children.
    a. Surviving children will receive weekly benefits until the child becomes 18, unless the child is enrolled in high school. In that event compensation shall continue until May 30th of the child's senior year in high school or until the child becomes 19 years of age, whichever is earlier.
    b. Surviving child will receive weekly benefits through the age of 23 if one of the following conditions are met:
        i. Dependent child is not physically or mentally capable of earning wages in any type of substantial and gainful employment; or

ii. Dependent child is a student enrolled full time in an accredited institution of higher education or vocational education.

c. Conservatorship required for minor children.

4. Cap –

a. $300,000.00 - For surviving spouse and wholly dependent children

i. Can exceed as children receive benefits above cap to age 18.

b. $100,000.00 – If no surviving spouse or wholly dependent children (all other dependents)

XII. REGULAR HEARING – FULL TRIAL

A. Hearing

1. Claimant generally testifies.
2. Each Party has 30 days after the hearing to put on evidence.
    a. Depositions of any and all witnesses.
    b. Parties may stipulate records into evidence.
3. Administrative Law Judge will enter an Award within thirty days of submission of evidence.
    a. Review and Modification stays open as a matter of law.
    b. Future medical treatment only awarded if the claimant proves it is more probable than not that future medical treatment will be required as a result of the work-related injury.
    c. Penalties again apply per K.S.A. 44-512a.

B. Review:

1. Award can be appealed within ten days to Kansas Appeals Board.
2. Can appeal Board decisions to Court of Appeals.
    a. No change at that level if substantial evidence to support Board decision.

C. Post-Award Hearings

1. Medical – K.S.A. 44-510k
    a. Claimant seeking medical treatment.
    b. Employer/Insurer seeking to modify or terminate award for medical treatment.
    c. Claimant's attorney can receive hourly attorney fees.
2. Review and Modification – K.S.A. 44-528
    a. Review if change of circumstances; i.e. increase in disability.
    b. Claimant's attorney can receive fees.

XIII. SETTLEMENTS – K.S.A. 44-531

A. Can obtain full and final settlement if claimant agrees.
1. Would close all issues.

B. Case can settle on Running Award per law.
1. Leaves future medical open on application to Director.
2. Respondent controls choice of physician.
3. Leaves right to Review and Modification open.

C. Most common settlement format is Settlement Hearing before Special Administrative Law Judge with a court reporter present.
1. FORMAT:
    a. Claimant is sworn in.
    b. Claimant is asked to describe his/her accident(s).
    c. Judge asks claimant if he/she is receiving any medical bills.
        i. Court will generally order payment of valid and authorized bills.
    d. Terms of settlement will be explained and read into record by Employer's attorney.
    e. Unrepresented claimant will receive explanation from Judge that he/she could hire an attorney.
        i. Explanation will detail that attorney could send claimant to a rating doctor of his/her choice – or claimant does not have to hire an attorney to get a rating from his/her own doctor.
    f. Most importantly, in a full and final settlement, the court will explain that claimant is giving up all rights to future medical.
        i. Additional payment can be made to compromise future medical.
    g. If claimant is out of state, settlement hearing can occur by telephone or by written joint petition and stipulation.

XIV. DEFENSES

A. Drugs and Alcohol – K.S.A. 44-501(b)(1)
1. Employer not liable if the injury was contributed to by the employee's use or consumption of alcohol or drugs.
2. There is a .04 level which will establish a conclusive presumption of impairment due to alcohol. Impairment levels for drugs set by statute.
3. Rebuttable presumption that if the employee was impaired, the accident was contributed to by the impairment.

4. Refusal to submit to chemical test results in forfeiture of benefits if the employer had sufficient cause to suspect the use of alcohol or drugs or the employer's policy clearly authorizes post-injury testing.
5. Results of test admissible if the employer establishes the testing was done under any of the following circumstances
    a. As a result of an employer mandated drug testing policy in place in writing prior to the date of accident
    b. In the normal course of medical treatment for reasons related to the health and welfare of the employee and not at the direction of the employer
    c. Employee voluntarily agrees to submit a chemical test

B. Coming and Going to Work – K.S.A. 44-508
1. Accidents which occur on the way to work or on the way home are generally not compensable.
2. Exceptions:
    a. On the premises of the employer.
    b. Injuries on only available route to or from work which involves a special risk or hazard and which is not used by public except in dealing with employer.
    c. Employer's negligence is the proximate cause
    d. Employee is a provider of emergency services and the injury occurs while the employee is responding to an emergency.
3. Parking lot cases – key question is whether employer owns or controls the lot.

C. Fighting and Horseplay – K.S.A. 44-501(a)(1)
1. Voluntary participation in fighting or horseplay with a co-employee is not compensable whether related to work or not.

D. Violations of Safety Rules – K.S.A. 44-501(a)(1)
1. Compensation disallowed where injury results from:
    a. Employee's willful failure to use a guard or protection against accident or injury which is required pursuant to statute and provided for the employee
    b. Employee's willful failure to use a reasonable and proper guard and protection voluntarily furnished the employee by the employer
    c. Employee's reckless violation of safety rules or regulations.
2. Subparagraphs (a) and (b) do not apply if:
    a. It was reasonable under the totality of the circumstances to not use such equipment; or
    b. The employer approved the work engaged in at the time of an accident or injury to be performed without such equipment.

XV. OTHER ISSUES

A. Retirement Benefit Offset – K.S.A. 44-510(h)
1. Applies to Work Disability cases only.
2. Can offset payments including Social Security Retirement.

B. Medicare Issues
1. Mandatory reporting requirements
2. Reconciliation of Conditional Payment Lien
3. Consideration of Medicare Set-Aside when closing future medical

XVI. RECENT LEGISLATIVE CHANGES (effective July 1, 2018)

A. K.S.A. 44-510b - Death Benefits:
1. Maximum burial expenses increased from $5,000.00 to $10,000.00.
2. Initial lump sum payment increased from $40,000.00 to $60,000.00.
3. Surviving children will receive weekly benefits until the child becomes 18, unless the child is enrolled in high school. In that event compensation shall continue until May 30th of the child's senior year in high school or until the child becomes 19 years of age, whichever is earlier.
4. If the employee leaves no legal spouse or dependent children but leaves other dependents wholly dependent upon the employee's earnings, maximum amount payable to such dependents is $100,000.00 (increase from $18,500.00).
5. If the employee does not leave any dependents who were wholly dependent upon the employee's earnings but leaves dependent partially dependent on the employee's earnings, maximum amount payable to partial dependents is $100,000.00. (Increase from $18,500.00).
6. If an employee does not leave any dependents, a lump sum payment of $100,000.00 shall be made to the legal heirs of the employee in accordance with Kansas law. (Increase from $25,000.00).
    a. However, if the employer procured a life insurance policy with beneficiaries designated by the employee and in an amount not less than $50,000.00, then the amount paid to the legal heirs under this section shall be reduced by the amount of the life insurance policy up to a maximum deduction of $100,000.00.

KANSAS WORKERS' COMPENSATION 201

HOW THE EMPLOYER CAN HELP ATTORNEYS IN WORKERS' COMPENSATION CLAIMS

I. Assist in Preparation of Contested Hearings

A. Preliminary Hearings
   i. Witness
   ii. Evidence

B. Most Common Issues
   i. Did accident arise out of an in the course of employment?
      1. Job duties
      2. What happened
      3. Were there any witnesses
      4. How and why did the accident occur
      5. When did the accident happen – date and time
      6. Is there past medical history
   ii. Notice
      1. Is there a designated person to receive notice of the accident
      2. Was notice given
         a. When
         b. To who
         c. Where did this take place
         d. What was said
         e. Was treatment authorized and provided
   iii. Employment
      1. Was accommodated employment offered
      2. Detail conversation
         a. Date of offer
         b. Verbal or written
         c. Who was present
         d. Detail any conversation that occurred regarding employment after
      3. Was there a resignation
         a. Written
         b. Verbal
      4. Unemployment
      5. Other employment
      6. Termination
      7. Personnel file
         a. Date of hire
         b. Reviews

C. Regular Hearings
    i. Witness
    ii. Evidence

II. Evidence

A. Personnel file
    i. Evaluations
B. Wages
    i. Calculate Average Weekly Wages
    ii. Temporary Benefits
C. Other valuable information on employee

III. Witnesses

A. Questions Regarding Accident:
    i. Who was/is in charge?
    ii. Who saw accident itself?
    iii. Who was told of accident?
        1. Notice prepared?
B. Employee's Work Status:
    i. Able to accommodate restrictions
C. If No Longer Employed:
    i. Witnesses as to leaving employer and circumstances surrounding
        1. Voluntarily left
            a. Able to accommodate restrictions
            b. Documented?
        2. Fired
            a. Occur after Workers' Compensation claim filed
            b. Able to accommodate restrictions
            c. Documented?

IV. Medical Information

A. Temporary or Permanent Accommodations
    i. Restrictions
    ii. Maximum medical improvement
    iii. Ratings
B. Employee's Performance and Communication with Employer
    i. Different than what they are telling Dr?
C. Understanding medical and procedures

Q. Is the AMA Guides, Sixth Edition constitutional in its application within the Kansas Workers Compensation Act?

A. Yes. K.S.A. § 44-510e(a)(2)(B) requires the use of competent medical evidence and the use of the AMA Guides, Sixth Edition is a starting point for medical providers.

Howard Johnson III sustained a cervical spine injury while working for U.S. Food Service. Dr. Harold Hess treated his cervical myeloradiculopathy and herniated discs by performing a neck fusion. After Mr. Johnson reached maximum medical improvement, Dr. Harold Hess provided a permanent partial impairment rating using the AMA Guides, Sixth Edition. He used the AMA Guides, Sixth Edition as prescribed by law per K.S.A. § 44-510e(a)(2)(B).

Mr. Johnson filed for workers' compensation benefits and among other issues, Mr. Johnson challenged the constitutionality of the Kansas Workers' Compensation Act's use of the AMA Guides, Sixth Edition to evaluate permanent partial general disability. The Kansas Court of Appeals held the use of the AMA Guides, Sixth Edition in the Kansas Workers' Compensation Act violated Section 18 of the Kansas Bill of Rights because it emasculated the Act to the point it no longer provided an adequate quid pro quo for injured workers who sustained permanent impairment for injuries on or after January 1, 2015.

The case was appealed to the Kansas Supreme Court.

The Kansas Supreme Court did not reach the constitutional questions addressed by the Kansas Court of Appeals. Instead, the Court held the language from K.S.A. § 44-510e(a)(2)(B) requires the use of the AMA Guides, Sixth Edition as a guideline supported by competent medical evidence.

The analysis involved the interpretation of K.S.A. § 44-510e(a)(2)(B) and its required use of the AMA Guides, Sixth Edition:

The extent of permanent partial general disability shall be the percentage of functional impairment the employee sustained on account of the injury as established by competent medical evidence and based on the fourth edition of the American medical association guides to the evaluation of permanent impairment, if the impairment is contained therein until January 1, 2015, but for injuries occurring on and after January 1, 2015, based on the sixth edition of the American medical association guides to the evaluation of permanent impairment, if the impairment is contained therein.

The Kansas Supreme Court dismissed the Court of Appeals interpretation which had removed the language "competent medical evidence" from injuries occurring on or after January 1, 2015. Further, the Kansas Supreme Court held "The use of the phrase 'based on' indicates the Legislature intended the Sixth Edition to serve as a starting point for the more important and decisive 'competent medical evidence.'" Ultimately, the Court held the percentage of functional impairment must always be proved by

competent medical evidence.

The AMA Guides, Sixth Edition remains the binding precedent for evaluation of an injured worker's permanent partial general disability. However, the Kansas Supreme Court held the AMA Guides, Sixth Edition is a starting point and the cases must be decided based on competent medical evidence. Thus, medical experts are not bound by the AMA Guides, Sixth Edition, but shall support an impairment rating with competent medical evidence.

Johnson v. U.S. Food Service, 478 P.3d 776 (Kan. 2021)

Q: Are the administrative law judge and board bound by the sixth edition in determining the extent of a claimant's permanent impairment for scheduled injuries pursuant to K.S.A. 44-510d(b)(23)?

A: Yes, while permanent partial general disability claims per K.S.A 44-510e(a)(B) allow for the use of competent medical evidence, permanent partial scheduled injury claims per K.S.A. 44-510d(b)(23) do not.

The claimant in this case worked for Goodyear Tire and Rubber Company for 10 years before sustaining an injury to the right shoulder in January of 2018. Claimant treated with Dr. Dempewolf for the right shoulder injury and ultimately Dr. Dempewolf issued an opinion on claimant's permanent impairment to the right shoulder. Using the AMA Guides 4th edition, Dr. Dempewolf opined claimant sustained 20% permanent partial impairment to the right upper extremity, and a 7% permanent partial impairment to the right upper extremity using the sixth edition.

In November 2019, claimant was evaluated by another orthopedic surgeon, Dr. Hopkins. Dr. Hopkins opined claimant sustained a 26% permanent partial impairment of the right upper extremity pursuant to the AMA Guides 4th Edition. Under the 6th edition, Dr. Hopkins determined claimant sustained a 16% permanent partial impairment of the right upper extremity. Claimant still works for his employer and therefore this claim is limited to functional impairment only.

K.S.A. 44-510e(a)(B) requires the extent of permanent partial general disability for unscheduled injuries to be established by competent medical evidence and based on the sixth edition. *Johnson v. U.S. Food Service,* 478 P.3d (2021) held that specifically, 44-510e(a)(2)(B) requires functional impairment rating be proved by competent medical evidence and use of the sixth edition is only a starting point for any medical opinion. "The use of the phrase 'based on' indicates the legislature intended the sixth edition to serve as a standard starting point for the more important and decisive competent medical evidence." *Id.* However, this language is different from 44-510d(b)(23) which says impairment of function related to a scheduled injury shall be determined using the sixth edition if the impairment is contained therein. 44-510d(b)(23) does not contain the phrase "competent medical evidence". As this case requires analysis under an impairment of function related to a scheduled injury, it shall be evaluated based upon the sixth edition and no other criteria.

This case scrutinizes two statutes against each other, resulting in a statutory interpretation issue. The court uses the plain meaning of each statute to evaluate its guidelines. As one statute simply leaves out a method of evaluation for an injury (using

competent medical evidence), the court reasoned that it must have been the drafters' intentions to remove that language from the statute even though a similar statute has the phrase in there. Further, this court was in no position to overturn this ruling based on a constitutional argument. This could likely see a further appeal based on constitutionality.

Butler v. The Goodyear Tire and Rubber Company, CS-00-0285-928 (2021).

Q: Under the "Heart Amendment" to the Workers Compensation Act, K.S.A. Supp. 44-501(c)(1), is evidence that an employer said a job duty is no longer a job duty and subsequently still required that employee to perform the duty enough to entitle a claimant to compensation?

A: No, even when an employer tells an employee a job duty is not their job duty, but then the employer changes their mind and requires the employee to perform that task, the job duty is within the normal scope of their employment for the purposes of determining compensation.

Thomas Larson's job duties required him to engage in domestic travel to address quality deficiencies impacting production. After suffering a heart attack in June 2016 on a trip, Thomas asked his supervisor to not travel anymore, and the supervisor agreed. However, shortly thereafter Excel switched supervisors, and Larson was again required to travel for his job. He became nervous and anxious about these trips. Thomas Larson suffered a fatal heart attack after returning from an out-of-town business trip with his employer in November 2016. This business trip was a bit more stressful and included many delays and changeover flights. His widow, Pamela Larson, sought surviving spouse benefits, but the Kansas Workers' Compensation Appeals Board determined she was not entitled due to what is commonly referred to as the heart amendment to the Workers' Compensation Act, K.S.A. Supp. 44-501(c)(1), because she failed to prove that Thomas' heart attack was caused by exertion beyond that usually required his job.

First, Pamela Larson argues that the Board misinterpreted K.S.A. Supp. 44-501(c)(1). The heart amendment provides, "Compensation shall not be paid in case of coronary or coronary artery disease . . . unless it is shown that the exertion of the work necessary to precipitate the disability was more than the employee's usual work in the course of the employee's regular employment." The heart amendment does not create a day-to-day test to measure usual exertion, usual work, or regular employment. Pamela argues that the Board misinterpreted the meaning of the heart amendment because it found an employee cannot recover under the heart amendment when performing the employee's usual work in the course of regular employment when the employee suffers a cardiac event. The Court of Appeals ruled that the Board did not misinterpret this provision. The Board's order found that the business trip was part of his usual work in the course of his regular employment.

Pamela then attempted to argue that the critical fact in this case is that the trip Thomas went on that resulted in a heart attack was *after* Thomas had complained to his boss about traveling and was told he would no longer have to travel, thus making traveling not part of his job duties. She also adds that this particular trip required more hours

than his job description. Both arguments failed due to the standard for determining what is usual exertion is the work history of the individual involved. While evidence existed that Thomas was told he would no longer be required to travel, he was also told by his new supervisor that travel *is* still included in his job duties. Beyond this, his previous job duties included travel, and this trip was no different than previous ones. The previous trips are to be evaluated and compared to this current trip, not the official job description.

The only chance Pamela has left of recovering is to show that an external factor was the precipitating cause of claimant's death. This alternative theory was dismissed as moot by the Board. To show an external force was the precipitating cause of the injury or disability, Pamela must prove "[1] the presence of a substantial external force in the working environment must be established and [2] there must be expert medical testimony that the external force was a substantial causative factor in producing the injury and resulting disability " *Mudd v. Neosho Memorial Regional Medical Center*, 275 Kan. 187, 191, 62 P.3d 236 (2003). Here, Pamela argued Thomas' stress arose from the severe winter weather cancelling his flight as well as a delay that led him to run out of medicine. The Court held "the fact that Pamela failed to prove that Thomas' heart attack was triggered by unusual exertions as part of his job does not necessarily preclude a claim that an external force triggered Thomas' heart attack. Thus, Pamela's alternative claim is not moot and remains unaddressed. The Board has a duty to evaluate Pamela's external force theory of recovery absent an explanation of why it is somehow moot." The Court remanded this issue to the Board.

Larson v. Excel Indus., Inc., 483 P.3d 1067, 1071 (Kan. Ct. App. 2021)

Q: Can a claimant who has a workers compensation act claim also pursue a negligence claim against his employer for the same accident?

A: No. The exclusive remedy provision of the Workers Compensation Act prevents a claimant from also suing for negligence when they are pursuing a workers compensation award.

On September 5, 2014, Loren Hopkins alleged he sustained an injury to his low back at work. After the injury he filed two subsequent claims: 1) a claim under the Kansas Workers' Compensation Act (the Act); and 2) a civil action against his employer, Great Plains Manufacturing, Inc. (Great Plains), alleging negligence.

First, with regard to the workers' compensation claim, there were conflicting medical opinions on whether claimant's work accident was the prevailing factor causing his low back condition or whether his low back symptoms were solely in aggravation of a preexisting condition. Ultimately, the Administrative Law Judge issued an award finding that the claimant suffered a strain as a result of the 2014 accident, but he had recovered from the strain and had failed to show that the accident caused any permanent injury or impairment. The workers' compensation award limited benefits to those already paid and denied any future benefits.

Second, with regard to the civil negligence lawsuit, Great Plains moved for summary judgment alleging that the exclusive remedy provision of the Act barred Hopkins' negligence claim. The district court agreed and granted the summary judgment

motion, in turn rejecting that if the Act barred his civil action, it violated Hopkins's rights under section 18 of the Kansas Constitutional Bill of Rights. Hopkins appealed this decision which is the subject of this case.

The Court of Appeals of Kansas turned to interpreting K.S.A. 2020 Supp. 44-501b(d) to decide this case. The provision states.

> "Except as provided in the workers' compensation act, no employer, or other employee of such employer, shall be liable for any injury, whether by accident, repetitive trauma, or occupational disease, for which compensation is recoverable under the workers' compensation act nor shall an employer be liable to any third party for any injury or death of an employee which was caused under circumstances creating a legal liability against a third party for which workers compensation is payable by such employer." K.S.A. 2020 Supp. 44-501b(d).

The court interpreted this statute to mean "that if a worker can recover benefits from an employer under the act for an injury, he or she cannot maintain a common-law action against that employer for damages based on a theory of negligence." *Fugit v. United Beechcraft, Inc.,* 222 Kan. 312, 314, 564 P.2d 521 (1977).

Hopkins argued that his injury was not recoverable under the Act because the court found that the work accident was not the prevailing factor causing the injury and thus did not award him permanent disability benefits or ongoing medical care. Accordingly, Claimant argued the exclusive remedy provision should not apply to bar a civil action. However, the Court highlighted that claimant had submitted into evidence a report from Dr. Fluter who found that claimant's work accident was the prevailing factor causing his low back condition. The Court explained, "Under these circumstances, it is incorrect to say that Hopkins could not recover under the Act as a matter of law for his ongoing medical needs. Hopkins would have fully recovered for his claims had the ALJ and the Board adopted Fluter's opinion. It was *possible* for Hopkins to fully recover for his claims under the Act, he simply failed to meet his burden of proof—at least according to the ALJ and the Board—and Hopkins made no attempt to seek judicial review of the Board's decision."

Ultimately, the Court held, "In sum, Hopkins recovered some compensation under the Act for his 2014 forklift accident, just not nearly as much as he wanted to recover because the Board rejected his claim that his work injury was the prevailing factor in causing his current back pain. Because compensation was recoverable under the Act, the exclusive remedy provision bars a civil action against Great Plains."

Hopkins v. Great Plains Mfg., Inc., 485 P.3d 1210 (Kan. Ct. App. 2021)

Q: *Does K.S.A. 44-503 extend to subcontractors in foreign states, and if so, would this offend the Due Process Clause by imposing personal jurisdiction over a subcontractor despite its limited contacts with Kansas as the forum state?*

A: Yes. **By contracting with a Kansas business for onsite labor, RGV submitted to personal jurisdiction in Kansas for workers compensation proceedings, consistent with the Due Process Clause of the Fourteenth Amendment to the United States Constitution.**

RGV owns and operates 45 Pizza Hut restaurants in Texas. The franchise agreement between RGV and Pizza hut details that RVG must adhere to many specific guidelines regarding how RGV operates each Pizza Hut, including what color the roofs are and how the roofs are maintained. RVG has no restaurants nor regularly conducts business in Kansas. However, over the years RGV has contracted with Shomberg, a Kansas corporation, from time to time to clean, repair, and paint the roofs on its Pizza Hut restaurants. For this project, the communications between RGV and Shomberg were mainly over e-mail; the two companies never signed a written contract for the 2016 work. Shomberg placed an ad for skilled workers and hired Christian White. White, Shomberg, and a third worker went to Texas in November 2016 to do the work for RGV. While working, White fell from the roof of one of the restaurants and seriously injured his leg. Shomberg is not available as a source of workers' compensation benefits, and the company has been dismissed from the action. White is now seeking to use K.S.A. 44-503 to claim workers' compensation benefits from RVG as the principal contractor.

K.S.A. 44-503(a) explains that the Workers' Compensation Act provides that those commercial entities contracting out work may in some circumstances become liable for benefits due to the subcontractor's employees for on-the-job injuries sustained while performing the subcontract. This statute shifts liability from Shomberg to RGV if it subcontracts work that is "part of its trade" or that it "contracted to perform". RGV attempted to argue that neither of these requirements applied, because there was no contract, and because roofing maintenance was not part of its trade, selling pizzas. The court held that RGV did not merely sell pizza, it sold Pizza Hut Pizzas, and maintaining the roof was part of operating a Pizza Hut. Because White was employed by Shomberg and then subcontracted out to RGV to do roofing work, an integral part of RGV's business, RGV is liable for White's injury.

As for the personal jurisdiction issue, the Court of Appeals of Kansas held that White's workers' compensation claim equally and plainly related to the contractual relationship. This was enough to satisfy the requirements of the Due Process Clause for personal jurisdiction over RGV in Kansas to adjudicate White's claim. Here, RGV purposefully sought out Shomberg in Kansas, and in doing so, RGV knew full well it was contracting with a Kansas corporation. This was not the result of randomness or general advertising. In addition, the Court viewed the work performed as more than an "incidental transaction." RGV likely knew that workers performing hazardous work on ten restaurants would be entitled to benefits should they become injured. This constitutes a direct solicitation of Shomberg to perform work with the known and ever-present risks that one or more workers might be injured on the job. This is sufficient to constitute minimum contacts.

White v. RGV Pizza Hut, No. 122,239, 2021 WL 2387963, at *2 (Kan. Ct. App. June 11, 2021).

Q: Can the Workers Compensation Fund sue a "Principal contractor" for benefits paid in a workers' compensation claim even if the principal contractor was not involved in the workers' compensation suit and is not "uninsured, insolvent, or a vanished employer" as mentioned in mentioned in K.S.A. 2020 Supp. 44-532a(a)?

A: Yes, K.S.A. 2020 Supp. 44-532a(b), gives the Fund a cause of action to recover what it has paid as workers' compensation benefits to injured workers.

Trademark is a contractor that hired Ballin as a subcontractor. Ballin subsequently hired Medina to perform physical labor for Ballin. Medina fell on the job and filed a workers' compensation action against Ballin. Ballin failed to maintain proper insurance, leaving Medina unable to recover from Ballin. Instead, Medina attempted to collect from the workers' compensation fund, and was able to collect $17,432.87. During Medina's action to collect from the fund, the fund tried to implead Trademark as the original contractor, but there was no statute to allow Trademark to be impleaded. Instead, the fund paid out the award and sued Trademark in a separate action for the full balance of the payment. The court ordered Trademark to pay the fund the full balance. Both parties now appeal, Trademark for a reversal, and the workers' compensation fund for an additional award of attorney's fees.

The Court of Appeals makes it clear that when Ballin failed to pay the workers' compensation claim, Medina could have received compensation from Trademark instead of the Fund. "The principal contractor is secondarily liable if the subcontractor fails to provide workers' compensation benefits to its employees." K.S.A. 44-503(g). In other words, if the subcontractor cannot pay, then the contractor will. The Court emphasized that the overall goal of workers' compensation cases are for the claimants to be paid out quickly and efficiently, and that who is going to ultimately be responsible for the payment can be sorted out later, such as it was in this case. The Court explained, "The creation of the Fund did not displace the long-standing rule that a principal remains contingently liable should a subcontractor be unable to pay an award. The worker is entitled to implead the Fund so the worker can be expeditiously paid. After the Fund satisfies a claim to the employee, the Fund "steps into the shoes of the employee" and may pursue a claim against the principal. This is all part of the sorting out process mentioned above." Ultimately, the Court held, "To sum up the law, we hold that for many reasons, the district court correctly granted judgment to the Fund over Trademark. The judgment promotes the aims of the Act—the prompt payment of benefits to injured workers, the responsibility of contractors to provide benefits for injured workers of their subcontractors, and duty of employers to reimburse the Fund."

Schmidt v. Trademark, Inc., No. 122,078, 2021 WL 2171608, at *1 (Kan. Ct. App. May 28, 2021)

Q. When an employee tests positive for use of illicit substances, can he still maintain a compensable Kansas workers' compensation claim?

A. Yes. An injured worker can maintain a compensable claim.

The law creates a rebuttable presumption that the accident was contributed to by the

drug impairment. The injured employee can overcome the presumption with clear and convincing evidence. The Kansas Supreme Court affirmed a decision by the Board of Appeals that the presumed impairment did not contribute to an employee's injury.

Gary Woessner died when he fell off of a catwalk. It was later determined that he had marijuana in his symptoms of at least over 50 nanograms per milliliter. It was later confirmed that his exact impairment was 189 nanograms per milliliter. The case was originally heard by the Administrative Law Judge who deemed the case non-compensable stating that the statutory requirements of K.S.A. 44-501 (b)(3) do not apply to the case as the employer did not take the sample directly. Specifically, K.S.A. 44-501 (b)(3) has six additional requirements if the employer took the drug test themselves. This includes collecting and labeling the samples under the supervision of a licensed health care professional, various laboratory requirements, the obtaining of a split sample, and additional rules of chain of custody. Ultimately, this was appealed to the Board of Appeals who found that the K.S.A. 44-501 (b)(3) was applicable and even if it was not, they felt that the claimant had established by clear and convincing evidence that his marijuana use did not contribute to the fall off of the catwalk causing his death. Apparently, the Board reviewed coworker's testimony indicating that prior to his death he did not see signs that the claimant was impaired.

The Court of Appeals addressed the issue and stated that they did not believe K.S.A. 44-501 (b)(3) applied but they believed that there were some questions regarding impairment and if it contributed to the injury and remanded the case back to the Appeals Board to make further determinations. Ultimately, the case was heard by the Kansas Supreme Court who found the Board appropriately weighed the evidence against the presumption: there was clear and convincing evidence showing that the marijuana usage did not contribute to claimant's death.

Woessner v. Labor Max Staffing, 471 P.3d 1 (Kan. 2020)

Q. What are the requirements when pursuing a psychological injury as a result of a work accident?

A. In order to establish a compensable claim for traumatic neurosis under the Kansas Workers' Compensation Act, K.S.A. 44-501 et seq., the claimant must establish: (a) a work-related physical injury; (b) symptoms of the traumatic neurosis; and (c) that the neurosis is directly traceable to the physical injury.

Most recently, in *Hughes v. City of Hutchinson*, the Court of Appeals affirmed the Board's finding that a worker did not sustain psychological injury after the Board: (1) noted the worker's hired psychologist was the sole professional to diagnose the worker with depression; (2) expressed concern Hughes did not seek opinions from treating medical professionals concerning depression; (3) the worker only consulted his hired psychologist 29 months after his injury and only based on his attorney's request; (4) the worker did not seek a preliminary hearing to request court-ordered mental health treatment while the matter was pending; and (5) the worker did not testify before the ALJ regarding his claims for depression and anxiety.

Hughes v. City of Hutchinson, 468 P.3d 348 (Kan. Ct. App. 2020)

Q. May preliminary orders be appealed from the Kansas Workers' Compensation Appeals Board to the Kansas Court of Appeals?

A. No. K.S.A. 2018 Supp. 44-556(a) provides for the appeal of final orders of the Board to the Court of Appeals, not preliminary orders. K.S.A. 2018 Supp. 44-534(a) states that preliminary hearings are "summary in nature" which provide an opportunity for a "full presentation of the facts" at the "full hearing on the claim." K.S.A. 2018 Supp. 44- 534a(a)(1) and (2).

In this case, employer appealed an ALJ's order directing claimant be treated by Dr. Eva Henry. Employer claimed that the administrative law judge had denied employer due process by ordering that Dr. Henry provide the treatment without first allowing the employer to submit two names of treatment providers for the judge to choose from under K.S.A. 2018 Supp. 44-510(h).

Employer argues that the Court of Appeals has jurisdiction because the administrative law judge denied it due process by failing to follow a statutory directive (that the employer be allowed to submit the names of two health-care providers for consideration if the administrative law judge decides a change in treatment provider is called for). This is distinguishable from previously decided cases concerning a preliminary order for continued medical treatment after the award of benefits had already been made. *Naff v. Davol, Inc.,* 28 Kan. App. 2d 726, 20 P.3d 738 (2001). Naff was a post award decision wherein a decision on the merits had already been decided after a full presentation of the facts. Naff is distinguishable as the case at point has not been decided in a final hearing.

There's a limited right of review for key issues that are jurisdictional to the workers'-compensation proceeding itself, like whether the injury arose out of the employment and whether the employee suffered an accident. But preliminary orders on those issues are subject to review by the board not a court. K.S.A. 2018 Supp. 44-534a(a)(2). The statute specifically precludes judicial review of preliminary orders even on these key issues. Preliminary orders are still subject to a full hearing on the claim and are not binding in resolving the underlying issues. Employer still has a chance to contest the decision made by the ALJ. Furthermore, if Employer makes payments it should not have made but for the ALJ's preliminary orders, the Employer shall seek compensation from the Fund.

Blakeslee v. Mansel Constr., 440 P.3d 627 (Kan. Ct. App. 2019).

Q. Is a claimant required to request an extension within three years of filing an application of hearing to avoid dismissal?

A. Yes. K.S.A. 2011 Supp. 44-523(f)(1) states that if a claim has not proceeded to a regular hearing, settlement hearing or a final award within three years from the filing of an application for hearing, an ALJ may grant a dismissal unless claimant has moved for an extension within the three years.

In this case claimant filed an application for hearing on December 5, 2012. Employer filed an application for dismissal on January 4, 2016 stating claimant had failed to move the claim toward regular hearing or settlement within three years pursuant to K.S.A. 2011 Supp. 44-523(f) . Claimant filed a request for extension of time to

schedule depositions and a regular hearing after the application for dismissal was filed. The ALJ dismissed the claim stating K.S.A. 2011 Supp. 44-523(f)(1) required the dismissal because claimant had not moved for an extension within three years of filing his application for hearing.

Glaze petitioned for the court's review of the following issues: (1) whether the panel erred in interpreting K.S.A. 2011 Supp. 44-523(f)(1) and dismissing his claim; (2) whether the panel erred when it held that K.S.A. 2011 Supp. 44-523(f)(1) requires dismissal of a claim when a motion to extend is not filed within three years of filing an application for hearing; and (3) whether the panel's interpretation of K.S.A. 2011 Supp. 44-523(f)(1) deprived him of due process under section 18 of the Bill of Rights of the Kansas Constitution. Review was granted on the first two issues.

The Board has consistently interpreted K.S.A. 2011 Supp. 44-523(f)(1) to mean that when a claim has not proceeded to a regular hearing, settlement hearing or a final award within three years from the filing of an application for hearing, an ALJ may grant an extension only if the claimant moved for an extension within the three years. See *Hackler v. Peninsula Gaming Partners, LLC*, No. 1060758, 2016 WL 858312 (Kan. Work. Comp. App. Bd. February 25, 2016); *Hoffman v. Dental Central*, No. 1058645, 2015 WL 4071473

(Kan. Work. Comp. App. Bd. June 26, 2015); *Ramstad v. U.S.D*. 229, No. 1059881, 2015 WL 5462026 (Kan. Work. Comp. App. Bd. August 31, 2015). The ALJ and the Board interpreted it in the same way here. The Court agrees that K.S.A. 2011 Supp. 44-523(f)(1) unambiguously prohibits an ALJ from granting an extension unless a motion for extension has been filed within three years of filing the application for hearing. Any other interpretation strains the common reading of the statute's ordinary language. This conclusion is confirmed when general rules of grammar and punctuation are applied. The Court of Appeals' conclusion that the statute unambiguously requires a party to move for extension within three years of filing an application for hearing is correct.

Glaze v. J.K. Williams, LLC, 439 P.3d 920 (Kan. 2019).

***Q. Is a claim which occurred prior to the 2011 Amendments but which had an* application for hearing filed after the 2011 Amendments took effect, subject to the 2011 Amendments?**

A. Yes. The Supreme Court concluded that K.S.A. 2011 Supp. 44-523(f)(1) requires the dismissal of a claim if claimant has not filed a motion for extension within three years from the filing of her application for hearing. In addition, the Supreme Court rejected claimant's argument that her claim shall be governed by the 2009 laws, rather than 2011 law, as she had not yet filed her application for hearing when the 2011 laws went into effect.

In this case, Knoll was injured while working for the school district on October 29, 2009. Knoll filed an application for hearing with the Kansas Division of Workers Compensation on November 14, 2011. On February 15, 2015, the school district and its insurer moved to have Knoll's claim dismissed pursuant to K.S.A. 2011 Supp. 44-523(f)(1), because the claim had not proceeded to a final hearing within three years of

the filing of an application for hearing. Knoll argued the motion to dismiss should be denied because K.S.A. 2009 Supp. 44-523(f) actually governed her claim and that version of the statute gives a claimant five years from the date of filing an application for hearing to file a motion for extension.

In a worker's compensation cases, the substantive rights between the parties are determined by the law in effect on the date of injury. However, amendments to the compensation act that are merely procedural or remedial in nature and that do not prejudicially affect substantive rights of the parties apply to pending cases. Generally, statutes of limitations are considered procedural. The 2011 amendment is not exactly a statute of limitations, but it is very similar. K.S.A. 2011 Supp. 44-523 establishes a time limit on completing a claim based on the date when the claim was filed. Similar to a statute of limitations, this statute cuts off a remedy and can be waived, lost, or extended by statute. If a workers compensation claimant filed an application for hearing under K.S.A. 44-534 after K.S.A. 2011 Supp. 44-523(f)(1) took effect, the 2011 statute governs the claim.

The Court concluded that K.S.A. 2011 Supp. 44-523(f)(1) applies to any cases that were pending during its enactment when the claimant did not file an application for hearing until after the 2011 amendments took effect. Though Knoll suffered her injury in 2009, she filed her application for hearing six months after the 2011 amendments became effective. Accordingly, K.S.A. 2011 Supp. 44-523(f)(1) controlled her claim. Because Knoll did not file her motion for extension until after the three-year time limit provided for therein, the Court of Appeals was correct when it reversed the Board's decision affirming the ALJ's denial of the school district's motion for dismissal.

Knoll v. Olathe Sch. Dist. No. 233, 439 P.3d 313, 317 (Kan. 2019).

Q. What is an "idiopathic cause" under Kan. Stat. Ann. 44-508(f)(3)(A)(iv)?

A. The Kansas Supreme Court defined the term "idiopathic causes" to refer to medical conditions or medical events of unknown origin that are peculiar to the injured individual under the Kansas Workers Compensation Act.

In this case, claimant worked as a forklift operator and was required to attend a paid safety meeting at the nearby headquarters. When the meeting ended, claimant walked to a restroom near the stairs and ended up face down on a landing at about the midpoint on the stairway, shattering or breaking three vertebra in his neck. The accident's cause remains a mystery.

Employer argued the fall's cause was unknown, which meant claimant's injuries arose from an idiopathic cause and were not compensable under the 2011 Amendments which excluded compensation for any accident or injury that arose either directly or indirectly from idiopathic causes. The 2011 Amendments however did not define the term idiopathic cause.

The court determined "idiopathic causes" refers to medical conditions or medical events of unknown origin that are peculiar to the injured individual. The court's decision reversed the interpretation given by the Workers Compensation Appeals Board, which denied Graber compensation. The court returned the claim to the board for reconsideration based on the court's definition.

Estate of Graber v. Dillon Companies, 439 P.3d 291, 301 (Kan. 2019).

***Q. Is prior authorization required for an employer to be liable for a claimant's medical* treatment?**

A. Yes.

In this case, the claimant sustained a compensable injury to her neck, lower back, and right arm. She then settled her case in 2013, leaving open her right to future medical care and review and modification. After her settlement, she received authorized care from multiple doctors. Her employer had also informed her that any referral from one doctor to another would not be authorized unless either her employer or the Administrative Law Judge preauthorized the treatment with the new doctor. However, the claimant also sought care from a podiatrist in 2014 to treat numbness, burning, and pain in her feet but did not obtain her employer's prior approval. The podiatrist recommended claimant to a neurologist who in turn recommended a biopsy. The biopsy did not determine the cause of her pain, and she was again referred to another doctor who the claimant treated with for seven to nine months before the doctor was designated as an authorized treating physician.

Claimant filed for a post-award medical hearing in September 2016 for reimbursement of her medical mileage. At the hearing, Claimant admitted she knew "no referrals from doctors were authorized unless either [her employer] or the ALJ clarified the orders beforehand." And that she ran four 5Ks, two 10Ks, one regular triathlon and one short course triathlon, and two half-marathons between November 2014 and June 2016. The Administrative Law Judge held the employer was not responsible for any of the mileage reimbursements for treatment claimant received without prior authorization and that the treatment was not related to her original work injury. Rather, it was related to her athletic activities. This decision was adopted by the Board, which held the treatment was unauthorized but did not address whether claimant's treatment was related to her work injury.

The Court of Appeals also did not determine whether the treatment was related to claimant's work injury or her athletic activities. The court did, however, affirm the Judge's and Board's determination that the treatment claimant was seeking reimbursement for was unauthorized. The court found it persuasive that throughout the period claimant was seeking unauthorized treatment, her employer had provided her with an authorized treating physician, she had attended appointments with that physician even after her settlement, and she had never received a bill for that treatment. Additionally, the court emphasized that claimant knew she had to seek prior approval of any referrals or medical treatment for it to be authorized and because she failed to do so, the treatment and any related travel expenses was unauthorized, and was not the employer's responsibility to pay.

Christenson v. Home Depot, No. 118,450, 2019 WL 985526 (Kan. Ct. App. Mar. 1, 2019).

Notes Pages

Notes Pages

Notes Pages

Notes Pages

MISSOURI WORKERS' COMPENSATION

I. JURISDICTION (RSMo § 287.110.2)

A. Act will apply where:
   1. Injuries received and occupational diseases contracted in Missouri; or
   2. Contract of employment made in Missouri, unless contract otherwise provides; or
   3. Employee's employment was principally localized in Missouri for thirteen calendar weeks prior to injury.

II. ACCIDENTS

A. Traumatic (RSMo § 287.020)
   1. An unexpected traumatic event or unusual strain identifiable by time and place of occurrence and producing at the time objective symptoms of an injury caused by a specific event during a single work shift.
   2. An "injury" is defined to be an injury which has arisen out of and in the course of employment. An injury by accident is compensable only if the accident was the **prevailing factor** in causing both the resulting medical condition and disability.
   3. "The prevailing factor" is defined to be the primary factor, in relation to any other factor, causing both the resulting medical condition and disability.
   4. An injury shall be deemed to arise out of and in the course of the employment only if:
      a. It is reasonably apparent, upon consideration of all the circumstances, that the accident is the prevailing factor in causing the injury; and
      b. It does not come from a hazard or risk unrelated to the employment to which workers would have been equally exposed outside of and unrelated to the employment in normal non-employment life.
      c. An injury resulting directly or indirectly from idiopathic causes is not compensable.
      d. A cardiovascular, pulmonary, respiratory, or other disease, or cerebrovascular accident or myocardial infarction suffered by a worker is an injury only if the accident is the prevailing factor in causing the resulting medical condition.
   5. An injury is not compensable because work was a triggering or precipitating factor.

B. Repetitive Injuries/Occupational Disease (RSMo § 287.067)

1. Occupational disease is an identifiable disease arising with or without human fault out of and in the course of the employment.
2. Ordinary diseases of life to which the general public is exposed outside of the employment shall not be compensable, except where the diseases follow as an incident of an occupational disease as defined in this section.
3. The disease need not to have been foreseen or expected but after its contraction it must appear to have had its origin in a risk connected with the employment and to have flowed from that source as a rational consequence.
4. With regard to occupational disease due to repetitive motion, if the exposure to the repetitive motion which is found to be the cause of the injury is for a period of less than three months, and the evidence demonstrates that the exposure to the repetitive motion with the immediate prior employer was the prevailing factor in causing the injury, the prior employer shall be liable for such occupational disease.
5. The employer liable for occupational disease is "the employer in whose employment the employee **was last exposed to the hazard of the occupational disease prior to evidence of disability.**"
    a. For repetitive motion claims, if exposure is for less than three months and exposure with prior employer is prevailing factor in causing the injury, prior employer is liable.
    b. "Evidence of disability" is a term of art. It is often felt to refer to an impact on an Employee's earning capacity.

III. NOTICE (RSMo § 287.420)

A. 30 days to report traumatic accident to Employer.

B. In repetitive trauma/occupational diseases, Employee has 30 days from the date a causal connection is made between the occupational disease and the employment to report the occupational disease to the employer.

C. The notice must be written and include the time, place and nature of the injury, and the name and address of the person injured.

D. Employee can overcome a notice defense by providing Employer was not prejudiced by the failure to provide timely notice.

E. If Employee can show that Employer had actual notice of the injury, even if the notice was not provided by Employee, the written notice defense may fail.

IV. REPORT OF INJURY (RSMo § 287.380)

A. A Report of Injury shall be filed for all claims that result in lost time or require medical aid other than immediate first aid.

B. Advise all employers to complete a Report of Injury as soon as possible and file with the Division of Workers' Compensation in Jefferson City, Missouri.

C. <u>Failure to file Report of Injury within 30 days of accident results in extension of statute of limitations from two to three years from the date of accident or date of last benefits paid, whichever is later.</u>

D. File Report of Injury regardless of whether a claim is being denied. Filing is not an admission of compensability.

E. Civil and criminal penalties possible for failure to file the Report of Injury.

V. CLAIM FOR COMPENSATION (RSMo § 287.430)

A. Employee has two years from the date of accident or the last date payment was made for benefits to file a timely Claim for Compensation.

B. If Employer did not file a Report of Injury within 30 days of accident, Employee has three years from the date of accident or the last date payment was made for benefits to file a timely Claim for Compensation.

C. On occupational disease claims, Employee has 2 years from the date at which a causal connection is made between the occupational disease and the occupational exposure to file a Claim for Compensation (3 years if Report of Injury was not filed timely).

VI. ANSWER TO CLAIM FOR COMPENSATION

A. If you receive a Claim for Compensation, assign the claim to counsel ASAP.

B. Answer must be filed within 30 days of notice from Division of Workers' Compensation.

C. <u>Failure to file timely answer results in acceptance of facts in claim, but not legal conclusions.</u>

D. Continue investigation and attempt settlement if appropriate.

VII. MEDICAL TREATMENT (RSMo § 287.140)

A. Employer provides treatment and selects providers.

B. Change of doctor only when present treatment results in a threat of death or serious injury.

C. Mileage is only paid when the exam or treatment is outside of the local metropolitan area from the employee's principal place of employment.

D. Vocational Rehabilitation

1. Never mandatory.
2. Used to take a potential permanent total to another vocation.
3. If requested by Employer, Employee must submit to "appropriate vocational testing" and a "vocational rehabilitation assessment."
4. 50 percent reduction in benefits if Employee fails to cooperate with vocational rehabilitation.

VIII. AVERAGE WEEKLY WAGE (RSMo § 287.250)

A. Need thirteen weeks of wage history in most cases.

B. Add gross amount of earnings and divide by number of weeks worked.

1. The denominator is reduced by one week for each five full work days missed during the thirteen weeks prior to the date of accident.
2. Compensation rate = 2/3 average weekly wage up to maximum.
3. Minors: consider increased earning power until age 21.

C. Part-timers: for permanent partial disability only, use thirty hour rule (30 hours x base rate). The thirty hour rule does not apply to temporary total disability.

D. Multiple employments: base average weekly wage on wages of Employer where accident occurred only. Do not include wages of other employers.

E. New employees: if employed less than two weeks, use "same or similar" full-time employee wages, or agreed upon hourly rate multiplied by agreed-upon hours per week.

F. Gratuity or tips are included in the average weekly wage to the extent they are claimed as income.

G. EXAMPLES:

1. Full-Time Employee
    a. Employee earned $9,600 in gross earnings for 13 weeks prior to injury.
    b. Employee missed five days of work during the 13 weeks prior to date of injury.
    c. Average weekly wage is $800.00 ($9,600.00/12)
2. Part-Time Employee
    a. $10 per hour
    b. Use 30 hour rule (30 hours X base rate)
    c. Average weekly wage is $300 (30 X $10.00)

IX. DISABILITY BENEFITS

A. Temporary Total Disability (RSMo § 287.170)

1. Compensation rate two-thirds Average Weekly Wage (AWW) up to maximum. (See rate card)
2. Multiple employments
    a. Base AWW on wages of employer where accident occurred only
    b. Do not include wages of other employers
3. Waiting period – three days of business operation with benefits paid for those three days if claimant is off fourteen days.
4. May not owe temporary total disability benefits if claimant is terminated for post-injury misconduct (RSMO § 287.170.4).
5. For accidents before August 28, 2017:
    a. A claimant may receive Temporary Total Disability benefits “throughout the rehabilitative process” regardless of whether the claimant has reached maximum medical improvement.
6. For accidents occurring on or after August 28, 2017:
    a. A claimant cannot receive Temporary Total Disability benefits after the claimant reaches maximum medical improvement.
7. If Employee voluntarily separates from employment when Employer offered light duty work in compliance with medical restrictions, neither TTD nor TPD shall be payable (RSMo § 287.170.5)

B. Temporary Partial Disability (RSMo § 287.180)

1. Two-thirds of difference between pre-accident wage and wage employee should be able to earn post-accident.

2. For accidents before July 28, 2017:

    a. A claimant may receive Temporary Partial Disability benefits “throughout the rehabilitative process” regardless of whether the claimant has reached maximum medical improvement.

3. For accidents occurring on or after July 28, 2017:

    a. A claimant cannot receive Temporary Partial Disability benefits after the claimant reaches maximum medical improvement.

C. Permanent Partial Disability (RSMo § 287.190)

1. "Permanent partial disability" means a disability that is permanent in nature and partial in degree.
2. Permanent partial disability or permanent total disability must be demonstrated and certified by a physician and based upon a reasonable degree of medical certainty.
3. On minor injury claims, the Administrative Law Judge (ALJ) may allow settlement without a formal rating report.
4. Part-time employees must use “same or similar” full-time employees wage. (For PPD only)
5. No credit for temporary total disability benefits paid.
6. There are no caps for benefits.
7. Disfigurement:
    a. Applicable to head, neck, hands or arms (RSMo § 287.190.4)
    b. Maximum is forty weeks.
8. If a claimant sustains severance or complete loss of use of a scheduled body part, the number of weeks of compensation allowed in the schedule for such disability shall be increased by 10 percent.
9. When dealing with minors, you must consider increased earning power for PPD (not TTD).
10. Calculation of Permanent Partial Disability
    a. Claimant has a rating of 10 percent permanent partial disability to the body as a whole.
    b. Claimant qualifies for the maximum compensation rate for his date of accident of $422.97.
    c. Value of rating would be $16,918.80. (400 wks X 10% X $422.97)

D. Permanent Total Disability (RSMo § 287.190)

1. Definition: inability to return to any employment, not merely the employment in which Employee was engaged at the time of the accident.
2. Benefits are paid weekly over Employee’s lifetime.

3. Law does allow lump sum settlements based on a present value of a permanent total award.

4. If Employee is permanently and totally disabled as a result of the work accident in combination with Employee's preexisting disabilities, and not as a result of the work accident considered in isolation, the Second Injury Fund is liable for PTD benefits.

E. Death (RSMo § 287.240)

1. Accidents before August 28, 2017:

a. Death resulting from accident/injury.

i. Total dependents (spouse and children) receive lifetime benefits.

ii. If spouse remarries, he/she receives only two additional years of benefits from remarriage date.

iii. Children receive benefits until the age of 18, or 22 if they continue their education full-time at an accredited school.

iv. Total dependents take benefits to the exclusion of partial dependents.

v. Partial dependents take based on the percentage of dependency.

vi. Lump sum settlements are allowed.

2. Accidents on or after August 28, 2017:

a. Total dependents now includes claimable stepchildren by the deceased on his or her federal income tax return at the time of the injury

b. Partial dependents no longer entitled to benefits

3. Death unrelated to accident.

a. Any compensation accrued but unpaid at the time of death is paid to dependents.

b. General Rule: if Employee was not at MMI at the time of death, no PPD is appropriate.

c. Benefits may continue to the dependents of Employee if Employee dies from unrelated causes.

X. PROCEDURE

A. Walk-In Settlement Conference

1. Scheduled at Division on a first come, first serve basis. Depending on venue, backlog generally two weeks to two months.

2. Settlement cannot be completed without Employee sitting before Administrative Law Judge with explanation of rights and benefits.

3. Settlement values can vary 3-7 percent between venues.
4. If Employee has scarring to upper extremities, head, neck or face, ALJ will assign disfigurement and the amount will be added to the amount of agreed settlement.

B. Conference

1. Set by the Division of Workers Compensation or at the request of Employer's counsel.
2. Purpose is to see if Employee is in need of treatment or is ready to settle the claim.
3. Claims need to be assigned to counsel.
4. Need to have a rating report, if applicable.
5. Many cases settle at this time.
6. If Employee fails to attend two Conferences, Division will administratively close the claim.

C. Pre-Hearing

1. After Claim for Compensation has been filed, the Division of Workers' Compensation will set Pre-Hearings.
2. Generally requested by a party.
3. Informal settings used to facilitate settlement or outlining of issues.
4. Alternatives at conclusion are:
    a. Mediation
    b. Continue and reset
    c. Settlement

Note: Unrepresented Employees are entitled to Mediations, Hardship Mediations and Hearings; however, Judges generally recommend they obtain counsel before any of these procedures.

D. Mediation/Hardship Mediation

1. Set before ALJ.
2. Both parties are typically required to have ratings/or medical reports regarding treatment needs.
3. Defense counsel required to have costs of medical, temporary total disability, permanent partial disability and physical therapy.
4. Formal discussion on all issues in case, potential for settlement and defenses.
5. Defense counsel must have access to client for settlement authority.

6. Alternatives at conclusion:
    a. Settlement
    b. Reset for Mediation
    c. Reset for Pre-Hearing
    d. Moved to Trial docket

E. Hearing/Trial – (RSMo § 287.450)
    1. Before Administrative Law Judge only.
    2. St. Louis: Mediation conference before Chief Judge with assignment of trial judge if case not settled.
    3. Each party can receive one change of judge.
    4. Award generally issued within 30-60 days of trial.
    5. All depositions and medical evidence must be ready to submit the day of trial.

F. Hardship Hearings – (RSMo § 287.203)
    1. Only issues are medical treatment and temporary total disability benefits currently due and owing.
    2. Claim must be mediated first.
    3. After the mediation, hearing can occur 30 days thereafter.
    4. Court can order costs of the proceeding to be paid by party if they find the party defended or prosecuted without reasonable grounds.
    5. All depositions and medical evidence must be ready to submit the day of trial.

G. Notice to Show Cause Setting
    1. Will be set by the Division if Claim for Compensation has been filed and claim has been inactive for one year.
    2. Can be requested by Employer if thirty-day status letter was sent to opposing counsel and no response was received.
    3. If claim is dismissed, Employee has twenty days to appeal the dismissal.

H. Appellate Process
    1. The Labor and Industrial Relations Commission
        a. <u>20 days to appeal ALJ's award.</u>
        b. Review of the whole record.
        c. Labor member, commerce member and neutral member.

2. Court of Appeals

   a. <u>30 days to appeal LIRC decision.</u>

   b. Review questions of law only.

3. Supreme Court

   a. <u>30 days to appeal Court of Appeals decision.</u>

   b. Review questions of law only.

I. Liens

1. Spousal and Child Support Liens

   a. Lien must be filed with the Division of Workers' Compensation.

   b. Temporary Total Disability: the maximum withheld is 25 percent of the weekly benefit.

   c. Permanent Partial Disability: the maximum withheld is 50 percent of the total settlement.

   d. Benefits generally paid to the Clerk of the Circuit Court.

2. Attorney Liens

   a. Lien must be filed with the Division of Workers' Compensation.

   b. Must be satisfied prior to payout of proceeds.

XI. DEFENSES

A. Arising out of and in the course of:

1. There must be a causal connection between the conditions under which the work was required to be performed and the resulting injury. The injury results from a "natural and reasonable incident" of the employment, or a risk reasonably "inherent in the particular conditions of the employment," or the injury is the result of a risk particular to the employment.

   a. *Acts of God* - not compensable

   b. *Personal Assault* - generally compensable

   c. *Horseplay* - generally not compensable, unless commonplace or condoned by Employer

   d. *Personal Errands/Deviation* - generally not compensable

   e. *Personal Comfort Doctrine* - Accidents occurring while an employee is engaged in acts such as going to and coming from the restroom, lunch or break room are generally compensable.

f. *Mutual Benefit Doctrine* - An injury suffered by an employee while performing an act for the mutual benefit of the employer and employee is usually compensable.

g. *Mental Injury* - (RSMo § 287.120.8) Claimant must show that mental injury resulting from work-related stress was extraordinary and unusual to receive compensation. The amount of work stress shall be measured by objective standards and actual events. Mental injury is not compensable if it resulted from any disciplinary action, work evaluation, job transfer, layoff, demotion, termination, or any similar action taken in good faith by the employer.

** Amendments made to the The Workers' Compensation Act in 2005 require that the statute to be *strictly construed*. This could potentially impact all common law doctrines such as the Personal Comfort Doctrine and Mutual Benefit Doctrine.

B. "In the course of"

1. Must be proven that the injury occurred within the period of employment at a place where the employee may reasonably be, while engaged in the furtherance of the employer's business, or in some activity incidental to it.

   a. *Coming and going* - Broad exceptions to this rule.

   b. *Parking Lot* - If Employer exercises ownership or control over the parking lot, an accident occurring on the lot will generally be found compensable.

   c. *Dual Purpose Doctrine* - If the work of Employee creates the necessity for travel, he/she is in the course of his/her employment, though he/she is serving at the same time some purpose of his own.

   d. *Frolic:* "Temporary Deviation"

C. Other Defenses

1. *Recreational Injuries* (RSMo § 287.120.7) - Not compensable unless Employee's attendance was mandatory, or Employee was paid wages or travel expenses while participating, or the injury was due to an unsafe condition of which Employer was aware

2. *Violation of Employer's Rules or Policies* - An employee is not necessarily deprived of the right to compensation where his injury was received while performing an act specifically prohibited by the employer. Compensation is denied where the employee's violation is such that it removes him from the sphere of his employment.

3. *Found Dead Presumption:* Where a worker sustains an unwitnessed injury at a place where the worker is required to be by reason of employment, there is a rebuttable presumption that the injury and death arose out of and in the course of employment. However, in almost all cases the courts have failed to permit recovery based on this presumption.

4. *Alcohol/Controlled Substances*

    a. For accidents before August 28, 2017:

        i. *Total Defense* [RSMo. §287.120.6(2)] - Must show that the use of the alcohol or controlled substance was the proximate cause of the accident.

        ii. *Partial Defense* [RSMo. §287.120.6(1)] - Employer is entitled to a 50 percent reduction in benefits (medical, TTD, and PPD) if Employer has policy against drug use and injury was sustained "in conjunction with" the use of alcohol or nonprescribed controlled drugs

    b. For accidents on or after August 28, 2017:

        i. If an employee tests positive for a non-prescribed controlled drug or the metabolites of such drug, then it is presumed that the drug was in Employee's system at the time of the accident/injury and that the injury was sustained in conjunction with the use of such drug.

        ii. For the presumption to apply, the following requirements must be met:

            (a.) Initial testing within 24 hours of accident or injury

            (b.) Notice of the test results must be given to the employee within 14 calendar days of the insurer/self-insurer receiving actual notice of the confirmatory results

            (c.) Employee must have opportunity to perform a second test upon the original sample

            (d.) Testing must be confirmed by mass spectrometry, using a generally accepted medical forensic testing procedure

        iii. The presumption is rebuttable by Employee

5. *Medical Causation*

6. *Employer/Employee Relationship*

    a. *Owner and Operator of Truck* - Complete defense if the alleged employer meets the standards set out in RSMo § 287.020.1.

    b. *General Contractor-Subcontractor Liability* (RSMo § 287.040) - Subcontractor is primarily liable to its employees and general contractor is secondarily liable. Under the Workers' Compensation Act, the general contractor has a right to reimbursement from the subcontractor if the subcontractor's employee receives benefits from the general contractor.

    c. *Independent Contractor* - The alleged employer must prove that the claimant is not only an independent contractor, but must also show that the claimant is not a "statutory employee."

7. *Intentional Injury* (RSMo § 287.120.3) – not compensable
8. *Last Exposure Rule* (RSMo § 287.063 and § 287.067.7)
9. *Idiopathic Injury* – "idiopathic" means innate to the individual
10. *Failure to Use Provided Safety Devices*: (RSMo § 287.120.5) If the injury is caused by the failure of the employee to use safety devices where provided by the employer **OR** from the employee's failure to obey any reasonable rules adopted by the employer for the safety of employees, the compensation shall be reduced at least 25 percent, but not more than 50 percent. Employee must have actual knowledge of the rule and Employer must have made reasonable efforts to enforce safety rules and/or use of safety devices prior to the injury.

XII. TORT ACTIONS AGAINST EMPLOYERS – The *Missouri Alliance* Decision

A. Labor groups challenged the constitutionality of the 2005 amendments.

B. If a work-related incident meets the definition of "accident" and if it causes "injury" as defined by the Act, then workers' compensation is the "exclusive remedy."

C. If not, the employee is free to proceed in tort.

D. Types of injuries and accidents at issue:
   1. Injuries that do not meet the definition of "accident," including repetitive trauma injuries;
   2. Accidents that do not meet the definition of "injury";
   3. Injuries for which the accident was not the "prevailing factor," but was the "proximate cause";
   4. Injuries from idiopathic conditions.

E. Likely types of claims:
   1. Common law negligence;
   2. Premises liability;
   3. Respondeat superior.

MISSOURI WORKERS' COMPENSATION 201

I. Evidence of Disability

A. Permanent Partial Disability (RSMo § 287.190)

1. Disability that is permanent in nature and partial in degree, and … the percentage of disability shall be conclusively presumed to continue undiminished whenever a subsequent injury to the same member or same part of the body also results in permanent partial disability for which compensation under this chapter may be due.

2. Permanent partial disability or permanent total disability shall be demonstrated and certified by a physician. Medical opinions addressing compensability and disability shall be stated within a reasonable degree of medical certainty.

3. In determining compensability and disability, where inconsistent or conflicting medical opinions exist, objective medical findings shall prevail over subjective medical findings. Objective medical findings are those findings demonstrable on physical examination or by appropriate tests or diagnostic procedures.

B. Occupational Diseases (RSMo § 287.063 & 287.067)

1. An identifiable disease arising with or without human fault out of and in the course of the employment.
    a. Includes injuries due to repetitive motion
    b. Occupational exposure must be the prevailing factor in causing the resulting medical condition and disability.
    c. The disease need not to have been foreseen or expected but after its contraction it must appear to have had its origin in a risk connected with the employment and to have flowed from that source as a rational consequence.
    d. Generally, does not include ordinary diseases of life to which the general public is exposed outside of the employment, except where the diseases follow as an incident of an occupational disease as defined in this section.

2. Typically, the employer liable for compensation of occupational diseases is the employer in whose employment the employee was last exposed to the hazard of the occupational disease prior to evidence of disability, regardless of the length of time of such last exposure
    a. This is referred to as the "Last Exposure Rule"

3. An employee shall be conclusively deemed to have been exposed to the hazards of an occupational disease when for any length of time, however short, he is employed in an occupation or process in which the hazard of the disease exists
    a. Unless it is an occupational disease due to repetitive motion and the employee has been employed with the current employer for less than three months and there was exposure to the repetitive motion with the immediate prior employer which was the prevailing factor in causing the injury.
    b. In this case, the prior employer is liable.

II. Post-Injury Misconduct

A. Defined (RSMo § 287.170.4)

1. If the employee is terminated from post-injury employment based upon the employee's post-injury misconduct, neither temporary total disability nor temporary partial disability benefits are payable.

2. Post-injury misconduct does not include absence from the workplace due to an injury unless the employee is capable of working with restrictions, as certified by a physician.

B. Examples of Post-Injury Misconduct:

1. After the claimant was released to return to work on modified duty, and the employer had work within the restrictions available, the claimant both failed to return to work and failed to call in his absences each day, as was required per the employer's policy. The policy specifically required the employees to call their supervisor at least one hour prior to beginning their shift if they could not report that day, unless other arrangements were made. The employee neither called each day nor made other arrangements and was therefore terminated. The Commission held this was a termination for misconduct.

   Hicks v. Missouri Dep't of Corrections, No. 14-004926, 2019 WL 2412820 (Mo. Lab. Ind. Rel. Com. May 31, 2019).

2. An over-the-road truck driver sustained an injury to his back but failed to immediately tell his employer about it. A week later, the driver still had not told his employer and was driving a route from Louisiana to Dallas, Texas and then back to Kansas City. While driving from Dallas to Kansas City, his supervisor called him and requested he stop in Arkansas to pick up an additional load. The driver refused and merely said his back was hurting but

did not allege a work-related injury. His employer informed him if he did not pick up the load in Arkansas, he would be fired. The driver still refused to pick it up and he was terminated. The ALJ determined this was a termination due to post-injury misconduct but on appeal the Commission did not incorporate this portion of the decision because it decided the matter on other grounds.

Jones v. Harris Transportation, No. 06-086943, 2009 WL 3786109 (Mo. Lab. Ind. Rel. Com. Nov. 4, 2009).

C. Example of what is NOT post-injury misconduct:

1. Using leave time to cover four post-injury absences while the claimant was working light duty from April 2017 through January 2018, for the following reasons: workers' compensation doctor's appointment, a family emergency, car troubles, and a medical emergency. The employee was fired for "frequent absenteeism" as all four absences occurred in January 2018. However, the Commission held this was not post-injury misconduct.

   Lana v. Oldcastle, Inc., No. 17-022682, 2019 WL 1313591 (Mo. Lab. Ind. Rel. Com. Mar. 15, 2019).

III. Safety Violations

A. Defined (RSMo § 287.120.5)

1. Where the injury is caused by:
   a. The failure of the employee to use safety devices where provided by the employer, or
   b. From the employee's failure to obey any reasonable rule adopted by the employer for the safety of employees

2. The compensation and death benefit provided for herein shall be reduced at least twenty-five but not more than fifty percent IF:
   a. The employee had actual knowledge of the rule so adopted by the employer; and
   b. The employer had, prior to the injury, made a reasonable effort to cause his or her employees to use the safety device or devices and to obey or follow the rule so adopted for the safety of the employees.

B. Examples

1. Employer's rule required employees to keep all body parts within the confines of a forklift while it was "traveling." However, while a forklift was stationary, the employee stuck his left leg out of the forklift and his left foot was crushed by another forklift passing by. The Missouri Supreme Court

held the employee did not violate the employer's rule because the rule only applied when the forklift was "traveling" or in motion. In this case, the forklift was stationary when the employee stuck his leg out and therefore there was no safety violation.

Greer v. SYSCO Food Services, 475 S.W.3d 655 (Mo. 2015).

2. Employer's rule required employees to lock-out-tag-out every machine before it was repaired. This entailed cutting off the power to the machine (lock-out) and placing a tag at the lock-out point indicating who had locked out the machine and who was authorized to turn it back on (tag-out). The employer regularly distributed written safety materials and trained the employees on these procedures and warned the employees they could be disciplined if they did not follow the procedures. An employee turned off power to part of a machine but not all of it and therefore some of the machine continued to move while he worked on it. The employee's fingers were caught in the moving parts while he was working on it and were injured. The Court of Appeals held the employee had actual knowledge of the safety rule due to the employer's training, the training and threat of discipline also established the employer made a reasonable effort to cause its employees to follow the rule, and that the employee's injury was caused by his failure to follow the safety rule. Therefore, the Court of Appeals awarded a 37.5% reduction.

Thompson v. ICI American Holding, 347 S.W.3d 624 (Mo. Ct. App. 2011).

IV. Alcohol and Drug Rule Violations (Intoxication or Impairment Defense)

A. Definition (RSMo § 287.120.6)

1. The employee must fail to obey any rule or policy adopted by the employer relating to a drug-free workplace or the use of alcohol or nonprescribed controlled drugs in the workplace

2. Then either of the following two situations may apply:
    a. If the injury was sustained in conjunction with the use of alcohol or nonprescribed controlled drugs, the compensation and death benefit shall be reduced fifty percent.
        i. "In conjunction with": co-existing in time and space.

    b. If the use of alcohol or nonprescribed controlled drugs in violation of the employer's rule or policy is the proximate cause of the injury, then the benefits or compensation for death or disability shall be forfeited.
        i. "Proximate cause": combined with the tort law definition, whether the injury is the natural and probable consequence

of the claimant’s use of the alcohol or drugs in violation of the employer’s rule or policy.

B. Refusal

1. An employee's refusal to take a test for alcohol or a nonprescribed controlled substance, at the request of the employer shall result in the forfeiture of benefits IF:
    a. The employer had sufficient cause to suspect use of alcohol or a nonprescribed controlled substance by the claimant; OR
    b. The employer's policy clearly authorizes post-injury testing

C. Presumptions

1. Alcohol
    a. The voluntary use of alcohol to the percentage of blood alcohol sufficient under Missouri law to constitute legal intoxication shall give rise to a rebuttable presumption that the voluntary use of alcohol was the proximate cause of the injury.
    b. A preponderance of the evidence standard shall apply to rebut such presumption.

2. Drugs
    a. Any positive test result for a nonprescribed controlled drug or the metabolites of such drug from an employee shall give rise to a rebuttable presumption:
        i. That the tested nonprescribed controlled drug was in the employee's system at the time of the accident or injury and
        ii. That the injury was sustained in conjunction with the use of the tested nonprescribed controlled drug
    b. The presumption only applies if the following are met:
        i. The initial testing was administered within twenty-four hours of the accident or injury;
        ii. Notice was given to the employee of the test results within fourteen calendar days of the insurer or group self-insurer receiving actual notice of the confirmatory test results;
        iii. The employee was given an opportunity to perform a second test upon the original sample; AND
        iv. The initial or any subsequent testing that forms the basis of the presumption was confirmed by mass spectrometry using generally accepted medical or forensic testing procedures.
    a. This presumption may be rebutted by a preponderance of evidence

V. Going and Coming Rule and Traveling Employees

A. Going and Coming Rule

1. An employer is generally not liable for a claimant's injury if the claimant was injured while going to or coming from work.

2. Injuries sustained in company-owned or subsidized automobiles in accidents that occur while traveling from the employee's home to the employer's principal place of business or from the employer's principal place of business to the employee's home are not compensable. (RSMo § 287.020.5).

3. However, an injury will generally arise out of and in the course of employment, "when it occurs within the period of employment at a location where employee would reasonably be while engaged in fulfilling the duties of employment or something incidental thereto."

   Campbell v. Trees Unlimited, Inc., 505 S.W.3d 805, 815 (Mo. Ct. App. 2016).

B. Mutual Benefit Doctrine

1. Typically applies to arguably work-related activities that do not involve travel.

2. If the employee is injured while performing an action which is for the mutual benefit of both the employee and the employer, the injury will be compensable.

3. The employee's actions must provide some substantive benefit to the employer, and the benefit must be more than merely speculative or remote.

C. Dual Purpose Doctrine

1. Typically applies to arguably work-related activities conducted while an employee is traveling.

2. If the employee is traveling both for his own personal purposes and for purposes related to his employment, any injury sustained while traveling may be compensable if the employee can prove they "would have made the journey even though the private purpose was absent."

   Wilson v. Wilson, 360 S.W.3d 836, 846 (Mo.App.W.D.2011).

3. Claimant must prove he was furthering his employer's purposes when the accident occurred.

4. If claimant was on a distinct departure on a personal errand, his injuries are not compensable.
    a. Departure may be shown if the employee would not have been at the place he was injured, had the employee cancelled his personal errand.

D. Special Task Exception or Special Errand Rule

1. Coming and going rule does not apply when the employee, having identifiable time and space limits on his employment "performs a special task, or errand in connection with his employment."

   Baldwin v. City of Fair Play, No. 11-015959, 2012 WL 992473 (Mo. Lab. Ind. Rel. Com. Mar. 21, 2012); *Custer v. Hartford Ins. Co.*, 174 S.W.3d 602 (Mo. Ct. App. 2005).

2. "The journey may be brought within the course of employment by the fact that the trouble and time of making the journey, or the special inconvenience, hazard, or urgency of making it in the particular circumstances, is itself sufficiently substantial to be viewed as an integral part of the service itself."

   Custer v. Hartford Ins. Co., 174 S.W.3d 602, 614 (Mo. Ct. App. 2005).

VI. Mental Injuries

A. Two Types: Work-Related Stress and Traumatic Events (RSMo 287.120.8–10).

1. Mental injury resulting from work-related stress does not arise out of and in the course of the employment, unless it is demonstrated that the stress is work related and was extraordinary and unusual. The amount of work stress shall be measured by objective standards and actual events.

2. Mental injury does not arise out of and in the course of the employment if it resulted from any:
    a. Disciplinary action,
    b. Work evaluation,
    c. Job transfer,
    d. Layoff,
    e. Demotion,
    f. Termination or
    g. Any similar action taken in good faith by the employer.

3. Neither of the above diminish a firefighter's ability to receive benefits for psychological stress under 287.067.6, which concerns occupational diseases
    a. Firefighters of a paid fire department and peace officers of a paid police department may recover for psychological stress if the department is certified and a direct causal relationship is established. (RSMo § 287.067.6).

B. Work-Related Stress – Claimant must prove:

1. As judged by an objective standard based on actual events, the amount of stress the claimant endured was work related, extraordinary, and unusual;
    a. The "objective standard" is a reasonable person standard: "whether the same or similar actual work events would cause a reasonable [employee] extraordinary and unusual stress."

       Mantia v. Missouri Dep't of Transp., 529 S.W.3d 804 (Mo. 2017)

    b. Must put forth objective evidence, such as by having other employees in his or her profession testify as to what they experience in the course of their employment.

    c. These other employees do not have to work for the same employer at the claimant.

2. Claimant suffered a mental injury which was caused by this work-related stress.

C. Traumatic Event (RSMo § 281.120.1) – Claimant must prove:

1. The mental injury arose out of and in the course of the claimant's employment

2. Examples:
    a. A nurse was sexually assaulted by a patient and this caused her to develop an adjustment disorder. The Court of Appeals held this mental injury was compensable even though she suffered no physical injury. The claimant did not have to prove her stress was extraordinary or unusual because the mental injury resulted from a traumatic event.

       Jones v. Washington Univ., 199 S.W.3d 793 (Mo. Ct. App. 2006).

    b. Two students were fighting and a teacher who tried to break up the fight was slammed into the wall by the students, resulting in physical and mental injuries. Both the claimant's physical and mental injuries were compensable without her proving her stress was extraordinary or unusual because they both arose out of and

in the course of her employment and resulted from a traumatic, physical, event.

E.W. v. Kansas City Missouri School Dist., 89 S.W.3d 527 (Mo. Ct. App. 2002).

VII. Extension of Premises Doctrine and Parking Lots

A. Definition (RSMo § 287.020.5).

1. The extension of premises doctrine is abrogated to the extent it extends liability for accidents that occur on property not owned or controlled by the employer even if the accident occurs on customary, approved, permitted, usual or accepted routes used by the employee to get to and from their place of employment.

2. Doctrine still applies to injuries which occur on property which the employer owns or controls.
    a. Employer "controls" property when it exercises power over it, regulates or governs it, or has a controlling interest in it.

    Missouri Dep't of Social Services v. Beem, 478 S.W.3d 461 (Mo. Ct. App. 2015).

B. Examples:

1. Claimant was on a fifteen-minute break and was walking to her car to go home to let her dog out, when she slipped and fell on ice in her employer's parking lot and broke her ankle. The employer did not own the parking lot, but per the terms of the employer's lease, the employer was to pay for snow and ice removal in the parking lot and could transfer its interest in the parking lot without the landlord's approval. Therefore, the Commission held, and the Court of Appeals affirmed that the employer had sufficient rights in the parking lot to "control" it and therefore was liable for injuries which occurred in the parking lot. The claimant's injuries were consequently compensable even though she was not performing a work-related activity when she was injured.

    Missouri Dep't of Social Services v. Beem, 478 S.W.3d 461 (Mo. Ct. App. 2015).

2. Claimant clocked out from work and was walking to his car to go home when he slipped on ice in his employer's parking lot and seriously injured his ankle. The employer did not own the parking lot, rather, it was leased to the employer from its landlord. The lease stated the employer had the right to use the parking lot, but the landlord had to manage and maintain the parking lot and had the ability to move the location of the parking lot as well as rearrange or modify it as the landlord saw fit without the employer's input.

Therefore, the Commission held and the Court of Appeals affirmed that the employer did not "control" the parking lot. The employer therefore was not liable for injuries which occurred in the parking lot under the extension of premises doctrine and the claimant's ankle injury was not compensable.

Hager v. Syberg's Westport, 304 S.W.3d 771 (Mo. Ct. App. 2010).

VIII. Penalties Against the Employer

A. Failure of Employer to Comply with Statute or Order (RSMo § 287.120.4).

1. If a claimant's injury is caused by the employer's failure to comply with any Missouri statute or lawful order of the Division or Commission, the claimant's compensation and death benefits are increased fifteen percent.

B. Fraud or Noncompliance Statute (RSMo § 287.128)

1. It is unlawful for an employer to knowingly make or cause to be made any false or fraudulent:
    a. Material statement or material representation for the purpose of obtaining or denying any benefit;
    b. Statements with regard to entitlement to benefits with the intent to discourage an injured worker from making a legitimate claim;
        i. "For the purpose of subdivisions (6), (7), and (8) of this subsection, the term "statement' includes any notice, proof of injury, bill for services, payment for services, hospital or doctor records, x-ray or test results."
    c. Any employer violating the above may be found guilty of a class A misdemeanor and punished by a fine up to ten thousand dollars and/or up to one year in a county jail.
    d. Repeat offenders may be found guilty of a class D felony.

2. It is unlawful for an employer to prepare or provide an invalid certificate of insurance as proof of workers' compensation insurance.
    a. Any employer preparing or providing the invalid certificate may be found guilty of a class E felony and punished by:
        i. A fine up to ten thousand dollars, or
        ii. Double the value of the fraud, whichever is greater, and/or
        iii. Up to four years in prison.

3. An employer cannot knowingly misrepresent any fact to obtain workers' compensation insurance for less than the proper rate
    a. Any employer doing so may be found guilty of a class A misdemeanor
    b. Repeat offenders may be found guilty of a class E felony.

4. Employer's covered by the Act must have workers' compensation insurance

a. If an employer does not have insurance, they may be found guilty of a class A misdemeanor and punished by:
    i. A penalty up to three times the annual premium the employer would have paid if they had workers' compensation insurance, or
    ii. Up to fifty thousand dollars, whichever amount is greater
b. Repeat offenders may be found guilty of a class E felony.

5. Under subsection (8) it is a violation of Missouri law to "knowingly make or cause to be made a false or fraudulent material statement to an investigator of the division in the course of the investigation of fraud or noncompliance."
    a. Any employer doing so may be found guilty of a class A misdemeanor.

C. Failure to report (287.380.4)

1. If an employer knowingly fails to report any accident or knowingly makes a false report or statement in writing to the Division or Commission, they may be found guilty of a misdemeanor and punished by:
    a. A fine of not less than fifty nor more than five hundred dollars, or
    b. By imprisonment in the county jail for not less than one week nor more than one year, or
    c. By both the fine and imprisonment.

D. Failure to Pay a Temporary or Partial Award (RSMo § 287.510).

1. If a temporary or partial award is entered, and a final award is later entered which is consistent with the temporary or partial award, and the temporary or partial award has not been paid or complied with by the time the final award is entered, the Judge may order the amount which was previously ordered in the temporary or partial award but not paid by the time the final award is entered to be doubled in the final award.

2. An employer/insurer could be charged under 287.128.2 for "knowingly and intentionally refusing to comply with known and legally indisputable compensation obligations with intent to defraud."

3. Whether to award the penalty is discretionary and may be entered by the Administrative Law Judge or Commission.

E. Failure to Post Reasonable Notices that the Employer is Covered by the Act (RSMo § 287.127.3)

1. Employer's covered by the act must post the following notices at their place of employment:
    a. That they are covered by the Act

b. That the employees must report all injuries, and to whom the injuries must be reported, within thirty days of when the employee becomes reasonably aware the injury is work related or the employee risks the ability to receive compensation
c. Name, address, and telephone number of the insurer; or if self-insured, the name, address, and telephone number of the designated individual responsible for reporting injuries or the adjusting or service company designated to handle the employer's workers' compensation matters.
d. Name, address, and number of the Division of workers' compensation
e. That the employer will supply additional information upon request
f. That a fraudulent action by the employer, employee, or any other person is unlawful.

2. Any willful violation of the notice requirement may result in a class A misdemeanor and a punishment by:
    a. A fine of not less than fifty dollars nor more than one thousand dollars, or
    b. By imprisonment in the county jail for not more than six months or
    c. By both such fine and imprisonment, and

3. Each such violation or each day such violation continues shall be deemed a separate offense.

F. Catch-All Penalty (287.790)

1. If any employer violates any provision of the Act and a penalty is not specifically provided, the employer may be found guilty of a misdemeanor and punished by:
    a. A fine of not less than fifty dollars nor more than five hundred dollars or
    b. By imprisonment in the county jail for not less than one week and not more than one year or
    c. Both such fine and imprisonment.

RECENTLY ASKED QUESTIONS IN MISSOURI

FROM ISSUES ADDRESSED IN RECENT MISSOURI CASES

Q: Did the Commission err in denying claimant benefits because he included additional injuries and disabilities as well as non-medical considerations in a claim for PTD?

A: Yes. Legislative intent does not show a requirement for non-medical considerations and additional injuries to be excluded from an analysis of PTD benefit eligibility.

In *Klecka*, in 2014, while working as a welder, claimant suffered an injury to his left shoulder that constituted the primary injury in this matter. Claimant settled the primary claim with his employer for permanent partial disability for both physical and psychiatric injury. Claimant then pursued a claim against the Second Injury Fund on the basis of his history of work-related and non-work-related accidents and injuries. The Administrative Law Judge ruled in claimant's favor for PTD benefits and found claimant to be unable to return to work. The Fund filed an appeal to the Commission, citing the ALJ's misapplication of a statute. The Commission reversed the award, finding that to establish Fund liability for PTD benefits, claimant's burden was to prove that the combination of one qualifying preexisting disability equaling at least 50 weeks of PPD and the disability resulting from the primary injury rendered him PTD. Additionally, since claimant's experts and the ALJ considered claimant's other injuries and disabilities as well as non-medical considerations, claimant did not carry his burden of proof.

Claimant's first point on appeal relates that the Commission misinterpreted a relevant statute. Claimant's second point claims that the Commission ignored the overwhelming weight of the evidence in finding that he did not prove he was eligible for PTD benefits. The present court declined to address this point because claimant was correct that the Commission misinterpreted the statute. The Missouri Court of Appeals reversed the Commission's decision and awarded the claimant PTD benefits based on what the court considers the correct interpretation of the statute.
Additionally, the court considered three more inquiries. The first inquires whether the employer or Fund should pay when an employee becomes permanently and totally disabled after a work-related injury. The court held that, reading all sections of the statute together, the legislature expressed intent that PTD claims against the Fund are governed by the Missouri Statute 287.200, which includes claims brought against the employer in which it is alleged that the employee is PTD as a result of a primary injury.

The second inquiry deals with a 2013 amendment to section 287.220. The court examined an amendment to Missouri Statute 287.200 which aimed to address the Fund's insolvency by limiting the Fund's liability. The Missouri Court of Appeals found that the 2013 amendment is consistent with historical framework but does not alter the fundamental purpose of the Fund, which is to encourage the hiring of disabled workers. The court also noted that when questioning who pays a claimant PTD after a primary injury, the tighter the restrictions are on Fund liability, the more PTD liability falls back on employers.

The final inquiry pertains to legislative intent to preserve the consideration of relevant medical and non-medical facts in PTD claims against the Fund. In this case, even though it is undisputed that the claimant is entitled to PTD and had a qualifying disability, the consideration of medical and non-medical facts by claimant's counsel meant that claimant did not meet his burden of proof. The court notes that because claimant did meet his burden of proof, statutory intent must be examined. The 2013 amendment demonstrates an intent to extend a PTD analysis beyond what was given by the Commission. The court goes on to say that by the statutory language, the legislature instructs us to look through the lens of qualifying injuries when deciding who pays for an employee's PTD. To give all parts of the statute meaning, one must consider the claimant's physical conditions as well as other considerations such as age, education, and transferable work skills when determining PTD. The court reversed the Commission's decision and remanded the matter for the entry of an award in claimant's favor.

Klecka v. Treasurer of Missouri, No. ED 108721, 2021 WL 2546417 (Mo. Ct. App. June 22, 2021).

Q: Did the Commission correctly find that claimant did not qualify for benefits because he did not prove that his disability resulted from a combination of the primary injury and a single, pre-existing disability?

A: No. By showing that a primary injury resulted in PTD when combined with multiple preexisting disabilities, a claimant employee can meet the statutory requirement needed to recover benefits.

In *Lexow*, claimant was employed by multiple different employers after being discharged from the United States Air Force. In 2003, claimant developed bilateral carpal tunnel syndrome because of repetitive work he performed for his employer at the time. After undergoing bilateral carpal tunnel release surgery the following year, claimant continued to experience weakness and had limited endurance and dexterity. Claimant settled with his then-employer for a permanent partial disability award. In 2008, claimant then began his employment with Boeing Company. After seven years with Boeing, claimant developed increased numbness and tingling in his left arm and hand. Shortly after, claimant was diagnosed with left CTS. Claimant then filed a workers' compensation claim against his employer and settled for permanent partial disability. Claimant also filed a claim against the Second Injury Fund alleging permanent and total disability due to his numerous pre-existing conditions and the injury sustained while working for Boeing.

The ALJ issued an award in favor of claimant finding claimant permanently and totally disabled due to the combination of his primary and preexisting injuries and disabilities. The Second Injury Fund appealed the award to the Commission. The Commission summarized that claimant believes he is incapable to returning to work or sustaining work due to his ailments. Claimant's medical expert opined that claimant was permanently and totally disabled resulting from a workplace injury and his preexisting conditions. A vocational rehabilitation counselor opined that claimant was not capable of work and factored in his preexisting conditions. The Commission concluded that under a new statutory test, a claimant must prove that a permanent disability results

from a combination of the primary injury and a single, preexisting disability that meets the 50-week threshold and category set forth under the statute. The Commission held that only some of claimant's preexisting conditions satisfied the statutory requirements and that there was no evidence that claimant was unable to work, meaning that claimant did not establish that permanent and total disability as required by statute.

In the instant matter, the case sits before the Missouri Court of Appeals. Claimant first argued that the Commission erred in reversing the ALJ's award on the ground that claimant did not meet his burden of proof under the statute. Claimant contended that even though the expert witnesses considered disabilities not covered by the statute in their analysis, there was evidence that claimant was permanently and totally disabled even if the non-qualifying disabilities were excluded. In his second point, claimant contended that the Commission misapplied the statute because the language and framework provide for benefits as a result of the combination of the primary injury and all of his preexisting disabilities, even the ones that do not qualify under the statute. The Missouri Court of Appeals for the Eastern District held that since claimant's primary injury that precipitated his PTD claim against the Fund happened after 2014, the Commission correctly applied the relevant statute, Missouri Statute 287.200. The statute provided multiple subsections that affected the Fund's liability for permanent partial and permanent total disability benefits based on the date of the injury. The present court held that the Commission misinterpreted the statute and erred in finding that PTD benefit eligibility must be proven by a combination of the primary injury and a single, qualifying disabling condition. The court remanded this matter to the Commission to make factual findings as to which one of claimant's preexisting conditions qualify under the eligibility criteria listed in the statute to determine if he qualifies for PTD benefits.

In his third point, claimant argued that the Commission erred in failing to consider claimant's 2003 workers' compensation claim involving an occupational disease resulting from repetitive trauma, as evidence of a qualifying disability under the statute. Additionally, the Fund argued that the Commission was correct in finding that claimant's bilateral carpal tunnel syndrome does not satisfy the statutory requirements because the word "injury" in the statute was not meant to include occupational disease. The present court found that the Commission erred in its finding because the plain language of the statute only required a compensable injury. Because another related statute specifically recognizes occupational disease as a compensable injury and does not exclude certain injury categories, the Commission was incorrect in not regarding the occupational disease as an injury. The court remanded the matter to the Commission to determine if claimant's 2003 occupational disease claim satisfies the rest of the statutory criteria.

Lexow v. Boeing Co., No. ED 108853, 2021 WL 1880933 (Mo. Ct. App. May 11, 2021)

Q: Were an employee's work duties the prevailing factor causing his thumb injury?

A: No. The facts found by the Commission supported the theory that the employee's work duties did not cause his thumb injury, but rather that the injury was arthritis related.

In *Mirfasihi*, the appellant employee began his employment at Honeywell in 1984 working as an electrical engineer and later as a program manager. Most of his job

duties included writing proposals and reports, compiling presentations, and overseeing those who worked under him. Between December 2016 and January 2017, the employee reported pain in his left hand to his manager, pain which he said progressed throughout the workday. He associated this pain with using the keyboard space bar with his left thumb. X-rays of the employee's hand revealed osteoarthritis and mild to moderate degenerative changes in the DIP joints. A doctor concluded that the most likely cause of the employee's symptoms was the osteoarthritis and not his work-related activities. Because of this, Honeywell did not accept the employee's claim as compensable and did not pay for any future medical care for his left thumb.

On July 5, 2017, the employee filed a claim with the Division of Workers' Compensation, claiming that he had a "left hand and left thumb repetitive motion injury or disease" from his employment at Honeywell. The employee was given a steroid injection to help with the pain, but claimed the pain came back shortly after treatment. Dr. Neighbor, an orthopedic surgeon, examined the employee's hand and opined that the medical bills the employee incurred were caused by the work injury. The employee underwent another examination and the examining doctor said that he did not believe hitting a spacebar would have caused employee's injuries.

During a November 8, 2019 hearing, the employee further claimed that his injuries stemmed from not only typing, but opening heavy government clearance doors, carrying his briefcase, and picking up his suitcase while traveling for his employer. On January 10, 2020, the Administrative Law Judge found that the employee sustained an occupational disease arising out of and in the course of his employment. Honeywell appealed, and the Commission ruled in its favor, citing the fact that the employee never informed his doctors of alternative causes for his thumb injury. On appeal, the Commission found that the employee did not meet his burden of proving his work duties caused his thumb injury. The employee alleged that the Commission erred by saying it did not have an expert opinion on the alternative injury theories and that the Commission erred in finding that he did not meet his burden of proof that his injury stemmed from his employment.

The Missouri Court of Appeals for the Western District held that although a previous doctor had opined that possible risk factors for a thumb injury may include gripping or squeezing, he did not specifically consider or comment on whether employee's alternate theories of injury actually caused his injury. Because of this, and the fact that the employee never mentioned to any doctors the alternative theories of how the injury happened, the court found the appellant's point to be erroneous. The present court also held that the Commission also correctly considered evidence as to whether the employee's work duties caused or aggravated the employee's osteoarthritis. The court reiterated that the question of whether the employee's osteoarthritis contributed to his thumb issues is not relevant here, and that the pertinent question is whether the employee's work activities caused his medical condition. Proving that his osteoarthritis contributed to his thumb pain without first establishing that the work conditions caused the osteoarthritis or thumb condition does not establish the "out of and in the course of employment" requirement. The court affirmed the Commission's decision in denying the employee compensation.

Mirfasihi v. Honeywell Federal Manufacturing & Technologies, LLC., 620 S.W.3d 658 (Mo. Ct. App. 2021).

Q: Did the ALJ err in granting the Division of Workers' Compensation exclusive jurisdiction over claimant's case, even though the claimant contends that the cause of action stems from failure to provide medical attention rather than a workplace accident?

A: **No**, the claimant's presence and purpose for being on the premises of where the accident occurred was solely due to his employment, therefore per statute, the Division of Workers' Compensation had the authority to consider the cause and extent of claimant's injuries arising from claimant's presence at his workplace.

When a claim involves the employer/employee relationship, the Division of Workers' Compensation has exclusive statutory authority to decide whether the injuries in question arose out of that relationship, even when the pleadings suggest that the employer had a duty of care to the claimant arising from another source.

In *Ducoulombier*, the decedent employee was found unresponsive on a work platform at Ford Motor Companies on February 25, 2016. A fellow employee began chest compressions on the employee, and another began mouth-to-mouth ventilation. Members of the workplace Emergency Response Team subsequently arrived and used an AED device twice on the employee. A call was then dispatched to the fire department, who, upon arrival, was met with workplace security and directed to a rendezvous point where they waited for the Emergency Response Team to bring them the employee. When the Emergency Response Team arrived at the rendezvous point, it was several minutes before the fire department and paramedics began treatment on the employee. One paramedic performed oral suctioning on the employee, finding several tobacco packets lodged in his airway. The decedent employee was declared brain dead at the hospital and after life support was withdrawn, passed away on February 29, 2016. Decedent's wife brought the present action.

On appeal, claimant alleged negligence by the employer through vicarious liability on the part of the workplace Emergency Response Team. Claimant further alleged that the employer did not properly prepare itself for medical emergencies, citing lack of necessary equipment, training, and established protocols. Two years prior to the instant appeal, claimant filed a workers' compensation claim alleging that the decedent suffered an injury during the course and scope of his employment that resulted in his death. That claim remained pending at the time of claimant's appeal.

Claimant alleged that the employer's negligence caused the decedent's death, arguing that the Missouri Supreme Court approved civil filings when it found that the injury comes within the definition of the term "accident", and that claimant could recover. But if the injury is not included within the meaning of "accident" then the injury is not subject to the exclusive jurisdiction provision of the Workers' Compensation Act. Claimant argued that the decedent's injury did not fall under the definition of "accident" and should not be subject to the exclusivity provision.

The court reasoned that if the employer believed the decedent's death was a result of the tobacco packets in his airway and not related to his employment, that it does not necessarily mean that it has conceded that the claim does not fall under workers' compensation law and would not warrant review by the workers' compensation

commission. However, the issue of whether the claim involved an employer/employee relationship is for the present court to decide. Because the decedent's reason for being on the employer's premises at the time of the incident was solely due to his employment, the matter falls under the purview of the Labor and Industrial Relations Commission.

Ducoulombier v. Ford Motor Co., No. WD 83430, 2021 WL 1377197 (Mo. Ct. App. Apr. 13, 2021).

Q: Did the court err in denying appellant's motion for substitution of parties, barring her receiving benefits, even though she presented evidence that she was the injured employee's dependent?

A: No. While an employee's right to permanent total disability benefits survives to his or her dependents upon the employee's death from causes unrelated to the workplace injury, the mere mention in the final award that the employee is married is insufficient to establish dependency at the time of the injury. (*Matthews v. Treasurer of Missouri).*

In *Matthews*, the deceased employee sustained a work-related injury on March 1, 2003. He settled with his employer and later pursued a claim for permanent total disability benefits with the Second Injury Fund. On April 27, 2015, the Administrative Law Judge awarded the employee permanent total disability benefits. The Fund appealed to the Labor and Industrial Relations Commission, which affirmed the Award on January 20, 2016. While the Award did refer to the employee's wife of thirty-one years, it did not mention any findings regarding the employee's dependents or the applicability of benefits. Per the Award, the Fund paid the employee weekly benefits until his death on March 11, 2020, which was unrelated to his injury. Appellant then filed a Motion for Substitution of Parties to receive her late husband's disability benefits.

Appellant appealed the Commission's dismissal of her motion to be substituted as a party in the workers' compensation matter of her late husband. In the motion, appellant noted that she was the deceased employee's dependent which would entitle her to receive her late husband's permanent total disability benefits as awarded by the Second Injury Fund. Appellant cited *Schoemehl v. Treasurer of State* as a basis to receive benefits.

In *Schoemehl*, the Supreme Court of Missouri held that an employee's right to permanent total disability benefits survives to his or her dependents upon the employee's death from causes unrelated to the workplace injury. This case was amended in 2008, making recovery limited to situations where the injured employee's case was pending before the Division of Workers Compensation between January 2007 and June 2008, which is when legislation abrogating *Schoemehl* became effective. In the instant matter, the deceased employee's claim was pending during the requisite window, however the question became whether the issue was preserved. To be preserved, dependency must have been established at the time of injury at the time of the final award. The court noted that merely mentioning in the Award that the employee is married is not sufficient to establish dependency at the time of the injury. Although the final award mentioned that employee was married during a period that included the date of injury, it did not identify the appellant being his spouse, therefore

no dependency was established on that date.

Appellant also argued that the court should have examined the whole record and not just the final award, since the record included deposition testimony that named appellant as the decedent's wife at the time of injury. The present court had already rejected this argument previously and reiterated that dependency is established by what is included in the final award. The instant court affirmed the Commission's decision to deny appellant her late husband's permanent total disability benefits by denying her motion for substitution of parties.

Matthews v. Treasurer of Missouri, No. ED 109168, 2021 WL 1256643 (Mo. Ct. App. Apr. 6, 2021).

Q: Did the trial court err in granting summary judgment in favor of defendant?

A: Yes. Claimant correctly asserted that the trial court erred in granting summary judgement in favor of the insurance company because the latter did not prove that claimant's injury did not arise out of the course of the suspect's conduct.

In *Stosberg*, claimant was injured while working as a sergeant with the Missouri State Highway Patrol. A suspect on a motorcycle was stopped at a DUI checkpoint and refused orders to get off his motorcycle or to turn it off. Trying to apprehend the suspect, the claimant grabbed the suspect's backpack when the suspect accelerated the motorcycle forward, causing claimant to injure his neck while pulling the suspect from the motorcycle. Claimant lodged a claim against the Missouri State Highway Patrol for workers' compensation benefits for the injury he sustained. Claimant was awarded benefits and the settlement was approved by an administrative law judge. Claimant asserted a negligence claim against the suspect's estate, and two counts against the insurance company alleging a breach of the insurance agreement and vexatious refusal to pay. The trial court granted the insurance company's motion for summary judgment to the insurance company on the claims lodged by the claimant. Claimant appealed.

On appeal, claimant first argued that the trial court erred in finding that claimant's injuries did not arise out of the suspect's use of the motorcycle, which was necessary to recover under the insurance company's policy. The trial court granted summary judgment to the insurance company because it found that claimant's injuries did not arise out of the suspects ownership, maintenance, or use of the motorcycle as outlined in claimant's insurance policy. Claimant asserted that this was erroneous because the suspect's acceleration of the motorcycle was an inherent use of the motorcycle, so if the use caused the injury, then the injury arose out of the suspect's use of the motorcycle. In the present action, the court agreed with claimant and held that there was more than a temporal or spatial relationship between the motorcycle and claimant's injuries and held that the motorcycle going forward was indeed the cause of claimant's injuries, meaning that it arose out of the suspect's use of the motorcycle.

Claimant then argued that the trial court erred in finding that his claim was excluded by policy language. Claimant contends that the policy exclusion is not applicable because the workers' compensation insurer does not have a right to subrogation against first part coverage because applicable rules only provide for subrogation

against third persons. The present court agreed with claimant's contention, stating that whether a right to subrogation exists is contingent upon the language used in the specific provision. The language used did not apply to the insurance company, therefore there is no right to subrogation.

Finally, claimant contended that the trial court erred in finding that the legislature intended for workers' compensation to be his only remedy because the legislature required uninsured motorist (UM) coverage in every auto insurance policy without regard to the insured's occupation. The court held that because the insurance company did not point to any legal authority or public policy that deprives law enforcement officers of UM benefits just because the injured officer may be entitled to workers' compensation. The court reversed the trial court's grant of summary judgment in the insurance company's favor and remanded the matter for further proceedings

Stosberg v. Elec. Ins. Co., No. WD 83723, 2021 WL 445988 (Mo. Ct. App. Feb. 9, 2021).

Q. Was a Client Services Agreement terminated in sufficient time before an employee's murder to bar recovery of benefits for his surviving spouse?

A: No. QBS did not cancel the Client Services agreement prior to the murder of an employee. Because the agreement was not terminated in an adequate amount of time, QBS was indeed a co-employer of the decedent employee at the time of his death.

In *Ziade*, appellant started a medical transportation business in 2010. Her husband was an employee of the company. Prior to July 2015, the company had entered into a Client Services Agreement with Quality Business solutions (QBS), which made QBS a joint employer with the medical transportation business and would provide workers' compensation coverage for employees of the medical transportation business. On July 28, 2015, an employee for the medical transportation business murdered appellant's husband over a dispute involving the worker's pay. Appellant submitted a workers' compensation claim naming QBS and the medical transportation business as employers. QBS claims that it terminated the Client Services Agreement with the business prior to the murder. Appellant testified that the only letter she received that pertained to terminating the Agreement was postmarked on August 13, 2015, after the murder. QBS also claimed that judicial estoppel and collateral estoppel were appropriate because appellant testified that her husband was on a personal errand when he was murdered.

The instant court affirmed the lower court's judgment and found that QBS did not terminate its January 2015 Client Services Agreement and held that appellant's claim is not barred by collateral estoppel or judicial estoppel.

The first point on appeal examined whether the decedent employee was a QBS employee on the day he was murdered, with QBS claiming that the Administrative Law Judge did not provide any analysis for how the Client Services Agreement issue was examined, meaning that the Commission erred in adopting this information. The Judge found that QBS entered into the Client Services Agreement with the medical transportation business on January 8, 2015, which made QBS a co-employer of the

medical transportation business's employees, and furthermore, that QBS did not terminate the agreement prior to the employee's death. The present court held that the Judge was not required to further analyze why it made this factual finding, meaning that the Commission did not err in adopting the Judge's decision. The court went on to note that the August 2015 termination letter was the only letter that QBS could prove it sent, and that the August 2015 letter did not reference a January 2015 termination letter. Taking that information into account, the present court held that finding that the Agreement was not terminated was supported by sufficient evidence.

QBS also argued that the Commissioned erred in finding that this appellant's actions did not constitute a cause for judicial estoppel or collateral estoppel. The Commission found that the issues of judicial estoppel and collateral estoppel were outside the scope of its jurisdiction. The present court held that judicial estoppel and collateral estoppel are not outside of the Commission's jurisdiction because there was no authority prohibiting it from exercising jurisdiction over those issues. Furthermore, the present court decided that judicial estoppel was not appropriate because there was no evidence of any inconsistent statements from the appellant, nor were there any signs that she tried to mislead the courts. The present court held that collateral estoppel was not appropriate because identical issues were not litigated during previous proceedings as alleged by QBS.

Ziade v. Quality Bus. Sols., Inc., 618 S.W.3d 537, 551 (Mo. Ct. App. 2021).

Q: Is an Employer's usual business defined differently at a location where it only hires independent contractors for a statutory employment analysis?

A: No. Under strict construction of Section 287.040.1, it is not necessary for the Court to decide whether Section 287.040.1 is limited to a specific location when the statutory employee is injured when performing the usual business of the employer. The mere fact that an employer solely hires independent contractors at a single warehouse location instead of regular employees does not change its "usual business" at that specific warehouse.

In *Sebacher*, the claimant performed truck driving and delivery work as an independent contractor for the employer. The employer operated 18 warehouse distribution centers, and only hired independent contractors to perform work at the specific warehouse where claimant performed delivery work out of. The claimant worked full time delivering the employer's products out of the specific warehouse where only independent contractors worked. The claimant was assaulted by one of the employer's employees while working at the warehouse. The claimant filed a civil negligence claim against the employer and the employer filed a summary judgment motion arguing that the claimant's sole remedy was through workers' compensation because he was a statutory employee. The employer's summary judgment motion was granted.

On appeal, the claimant argued he was not a statutory employee because the court could only analyze the specific warehouse he worked at when determining what the employer's usual course of business was pursuant to Section 287.040.1. He argued that delivering products was not the employer's usual course of business at the specific warehouse he worked at because the employer never used its own

employees to perform work at that warehouse. The Court held that it was not necessary to look at the specific warehouse when determining usual course of business because the usual course of business of employer was the same at every warehouse, which was shipping and delivering products. The Court determined that the mere fact the employer used independent contractors instead of regular employees at the warehouse where the claimant was injured did not change the fact that the usual course of business was being performed there. The claimant was found to be a statutory employee.

Sebacher v. Midland Paper Company, 610 S.W.3d 402 (Mo. App. E.D. 2020).

Q: *Does a letter requesting a continuance of a dismissal setting from a claimant's attorney constitute a prima facie showing that the claimant is prosecuting his/her case when no other evidence is presented?*

A: No, more evidence of prosecution is needed or evidence of good cause for failing to prosecute. "[T]he allegations in [claimant's] application for review and in his attorney's letter – even if taken as true – failed to make a prima facie showing of good cause."

In *Hager*, the claimant sustained a work-related injury in 1997. The claimant settled his claim with the employer/insurer in 2002 and his claim against the Second Injury Fund remained open. Until early 2019, the claimant had routinely requested continuances of pre-hearing conferences set on his claim against the Fund. A pre-hearing conference was set in May of 2019 and the notice was undeliverable to the claimant when mailed. The Division advised claimant's attorney the notice was not deliverable and requested updated contact information. The claim was set on the dismissal docket in October of 2019 and the Administrative Law Judge dismissed the claim with prejudice because neither the claimant nor his attorney appeared. Claimant's attorney appealed the dismissal to the Commission and argued that prior to the dismissal setting he had faxed a letter to the division advising he could not reach the claimant, the claimant did not receive the dismissal setting notice, and he had hired a profession investigator to locate the claimant.

On review, the Court of Appeals affirmed that the case dismissal was appropriate because claimant had not presented a prima facie case that he was prosecuting his claim. The Court held that nowhere in the claimant's appeal or letter faxed by his attorney did the claimant or his attorney alleged facts that would establish a case of good cause for prosecuting the claim over the many years it had been pending.

Hager v. Treasurer of Missouri, 613 S.W.3d 87 (Mo. App. E.D. 2020).

Q: *Does an employee's violation of a reasonable rule adopted by the employer at the time of an injury take the employee outside the course of employment?*

A: Likely no. "Employer's general argument that [claimant's] violation of the safety rule takes him outside the course of employment would render 287.120.5 (safety reduction penalty) meaningless." "The legislature is presumed not to enact meaningless provisions."

In *Boothe*, the Claimant was an installer for a satellite television company. On the date of his injury, the claimant was driving employer's van to his first customer's house for

the day. While driving to the customer's location, the claimant choked while eating a breakfast sandwich, blacked out, and crashed into a pillar on the side of the highway sustaining injuries. The employer had a rule prohibiting its employees from eating or drinking while driving company vehicles. On appeal, the employer argued that the claimant was outside his course of employment because he was violating a company rule at the time the accident occurred.

The Court held that for an employee to be outside of the course of employment while violating an employer's rule, the violation of the rule must completely sever the employer-employee relationship. The Court also cited to section 287.120.5, which provides for a penalty on compensation when an injury occurs in conjunction with an employee violating a company rule. The Court determined that if an employee were held to be outside of the course of employment when violating a company rule, then Section 287.120.5's penalty would be rendered meaningless. Therefore, a safety penalty was applied to the claim but the claim was found to be compensable.

Boothe v. DISH Network, Inc., 2020 WL 7706398.

Q: *Is a deceased claimant's dependent, who is over the age of 18 and enrolled at an accredited educational institution part-time for a short period following turning 18 entitled to extended death benefits until the age of 22, pursuant to 287.240(3)?*

A. No. "[Decedent] failed to satisfy the prerequisite of enrollment and *continued* attendance as a *full-time student* at an accredited educational institution as of age 18 necessary to extend her dependency status until age 22."

In *Williams*, the claimant was killed in a work-related accident. The claimant's wife and dependents were provided death benefits following the accident. At the hearing before the Administrative Law Judge, the employer argued that the claimant's oldest daughter was not entitled to death benefits because she had turned 18 and did not qualify as a dependent under Section 287.240(3) for continuing death benefits until reaching the age of 22. The claimant's oldest daughter turned 18 years old on August 7, 2018. Evidence presented at the hearing showed that the claimant's oldest daughter was enrolled for three course credits at a community college between July 30, 2018 and December 14, 2019.

The Commission held that the claimant's oldest daughter failed to establish she was a dependent because she was not a full-time student as of age 18, nor was she continuing to attend an accredited educational institution after turning 18. The Commission also held that the statute for providing continued dependency status to children enrolled at education institutions until the age of 22 nowhere allows for a child who would otherwise qualify to revive his or her status as a dependent through later enrollment for a full-time course of study. Therefore, the dependent child must be enrolled full-time, and continue to attend an educational institution full-time after turning 18 to receive death benefits until the age of 22.

Jacob Williams v. Reeds, LLC, (Mo. Lab. Ind. Rel. Comm'n, Oct. 5, 2020).

Q: Does an employer/insurer expert physician's prevailing factor opinion for occupational toxic exposure claims use the incorrect legal standard when the physician bases the opinion in part on the lack of scientific studies showing a link between the occupation and disease (in this case mesothelioma).

A: Possibly, it is a fact intensive analysis. Here, the Court held that because the employer and insurer's physician based his prevailing factor opinion in part on the absence of scientific studies showing a link between the occupation and mesothelioma, that constituted a misapplication of law.

In 2014, the legislature added provisions to the Missouri Workers' Compensation Act allowing for claims alleging occupational exposure to toxic materials. One of the listed diagnoses required to trigger the enhanced remedy benefit statute is mesothelioma. Under the Act, § 287.063.1 states "an employee shall be conclusively deemed to have been exposed to the hazards of an occupational disease when for any length of time, however short, he is employed in an occupation or process in which the hazard of the disease exists."

In this case, the Administrative Law Judge and Commission had ruled that the employer and insurer's doctor was more persuasive in finding that the Claimant's alleged occupational exposure to asbestos from hair dryers was not the prevailing factor in causing his mesothelioma and death. The employer and insurer's doctor advised that there were no studies showing a link between the occupation of hairdressing and mesothelioma, while also advising that there were other unknown causes of mesothelioma and indicating that the claimant used some of the same hairdryers at home while off work. Additionally, the Commission and ALJ noted that while the claimant was able to provide brands of hairdryers he used at each employer, he was unable to recall the specific sub model, and therefore the documents showing which sub models contained asbestos did not show definitively that the hair dryers used by the claimant contained asbestos material.

On appeal, the claimant's widow argued that because employer and insurer's doctor based his prevailing factor opinion on whether or not there were studies definitively showing a link between hairdressing and mesothelioma, he and the judicial bodies that reviewed the case, applied the incorrect legal standard for determining the prevailing factor. The Court explained that while typically medical causation is a question of fact, the misapplication of the legal standard makes it a question of law subject to the Court's review. The Court further explained that the correct standard requires the claimant show "a **probability** that the working conditions caused the disease" and by requiring studies showing a **definitive** link between hairdressing and mesothelioma, the employer and insurer's expert opinion applied a different legal standard.

In conclusion, the Court found that the Commission acted without or in excess of its powers by failing to analyze medical causation and Mr. Hayden's date of injury under the proper legal standards.

Hayden v. Cut-Zaven, Ltd., 614 S.W.3d 44, (Mo. App. E.D. 2020).

Q: Does a death under the "line of duty" portion of the Missouri Workers' Compensation Act arise out of and in the course of his employment when a police chief loading boxes onto a delivery truck while on-call suffers a heart attack?

A: Probably not. Here, the court indicated that the police chief being on-call was not enough to establish that the injury arose out of and in the course of his employment as a police officer.

The court advised that there are a line of cases indicating whether or not the officer is technically on duty and is a factor in determining whether the accident arose out of and in the course of employment, but is not dispositive. In two cases, *Spieler* and *Mann*, the court indicated that the key issues were whether the actions performed by the officers were the kind they undertook in their role as officers, or if the officers were injured in a particular situation by virtue of being a police officer.

In this case, the police chief was on the dock loading packages into a delivery truck when he had a heart attack and died. The estate argued that because he was on-call as police chief during that time, he was in active performance of his job duties under the Act. The court held that under § 287.243.2(5), the officer was not in active performance of his job duties simply by being on-call as that would expand the meaning of the statute and create a result not intended by the legislature. Therefore, the court affirmed the Commission's decision denying benefits.

Estate of Newman by Eatherton v. City of Leadwood, 611 S.W.3d 529 (Mo. App. E.D. 2020).

Q: Is a claimant's knee injury, suffered by missing a step while walking down an ordinary flight of stairs at work while conducting a security check, a compensable injury under the Missouri Workers' Compensation Act?

A: No, not here. Section 287.120.1 provides that an employer "shall be liable, irrespective of negligence, to furnish compensation under the provisions of [the Act] for personal injury ... of the employee by accident ... arising out of and in the course of the employee's employment." For an injury to be compensable it must arise "out of and in the course of ... employment pursuant to section 287.020.3(2)." *Johme v. St. John's Mercy Healthcare*, 366 S.W.3d 504, 509 (Mo. banc 2012). There must be a causal connection between the injury at issue and the employee's work activity. *Id*. Section 287.020.3(2) provides that: "An injury shall be deemed to arise out of and in the course of the employment only if: (b) It does not come from a hazard or risk unrelated to the employment to which workers would have been equally exposed outside of and unrelated to the employment in normal nonemployment life."

In *Marks*, the employee was working for the Department of Corrections on November 9, 2017 and was descending a staircase while conducting a security check when he mis-stepped and felt his right knee twist. He reported the injury involved him simply stepping off the step wrong. He later testified he was looking back at another co-worker, to ensure the worker's safety, when the accident occurred. In finding the employee's testimony not to be credible, the ALJ denied benefits, finding "the accident occurred when [Marks] missed a step and did not arise out of and in the course of

employment." The LIRC affirmed the award of the ALJ denying benefits and the employee appealed. The Court of Appeals applied a two-part test, "which first requires identification of the risk source of a claimant's injury, that is, identification of the activity that caused the injury, and then requires a comparison of that risk source or activity to normal nonemployment life." In finding that the risk source of claimant's injury was descending stairs and was not entitled to an inferred heightened risk while conducting a security check, the Court found employee's injury resulted from a risk source which he is equally exposed in his nonemployment life. Thus, the Court affirmed the LIRC's denial of benefits under the Missouri Workers' Compensation Act.

Marks v. Missouri Dep't of Corr., 606 S.W.3d 159 (Mo. App. W.D. 2020).

Q: Are injuries sustained by an accidental trip and fall at a treating physician's office compensable when the claimant was treating for a work-related respiratory injury following a chemical exposure?

A: No. An injury "by accident is compensable only if the accident was the prevailing factor in causing both the medical condition and disability." Section 287.020.3(1). An injury must arise "out of and in the course of employment." Id. "For an injury to be deemed to arise out of and in the course of the employment under section 287.020.3(2)(b), the claimant employee must show a causal connection between the injury at issue and the employee's work activity." *Johme v. St. John's Mercy Healthcare*, 366 S.W.3d 504, 509-10 (Mo. banc 2012). For an injury to arise out of and in the course of her employment, an employee must demonstrate the accident is a prevailing factor of the injury and is not a risk that the claimant would have been exposed outside of and unrelated to the employment. Section 287.020.3(2)(a)-(b).

In *Schoen*, the employee appealed from the LIRC's decision denying benefits because employee failed to prove her work injury was the prevailing factor causing any permanent disability she suffered. On May 8, 2009, Employee was exposed to cypermethrin, an insecticide, while working as a charge nurse at Mid-Missouri Mental Health Center. Employee complained of throat and eye irritation; she also began coughing and wheezing. Employer sent her to the emergency room on May 11, 2009. Employee was prescribed medication and returned to work without any limitations. While attending an appointment at Dr. Runde's office, she tripped on a dog that had gotten loose in the office, and fell, sustaining injuries to her knees, lower back, hip, and neck. The employee filed an amended claim, asserting injuries from her fall in Dr. Runde's office.

The ALJ initially awarded benefits for both the cypermethrin exposure and the accidental fall, finding the trip and fall to be the "natural and probable consequence of" the cypermethrin exposure. Employer appealed and the LIRC reversed the award, finding the employee failed to prove the cypermethrin exposure was the prevailing or primary factor in causing any alleged injury from being tripped accidently at Dr. Runde's office. The employee appealed to the Missouri Court of Appeals and the matter was transferred to the Missouri Supreme Court.

The Court found Employee's risk of being tripped accidently is a risk she equally is exposed to outside of her employment. Any of Employee's injuries stemming from the accidental tripping did not occur because of a condition of her employment. See, e.g.,

Annayeva v. SAB of the TSD of the City of St. Louis, No. SC98122, 597 S.W.3d 196, 200, (Mo. banc March 17, 2020) (finding a teacher who slipped in the hallway of the school where she taught was not entitled to workers' compensation benefits because she was unable to prove a causal connection with her employment). The Court found the assertion of simple but-for causation by the employee insufficient to establish a causal connection with her work. The Supreme Court affirmed the LIRC's denial of benefits for the accidental tripping incident while claimant was in the physician's office for treatment involving her cypermethrin exposure.

Schoen v. Mid-Missouri Mental Health Ctr., 597 S.W.3d 657 (Mo. 2020).

Q: Whether the LIRC, in determining the Second Injury Fund's (SIF) liability for an employee's permanent total disability, was required to determine that employee's preexisting disease was symptomatic at the time of the employee's primary compensable injury?

A: No. Section 287.220.2 provides for SIF liability for workers who are permanently and totally disabled by a combination of past disabilities and a primary work injury. *Payne v. Treasurer of State, Custodian of Second Injury Fund*, 417 S.W.3d 834, 847 (Mo. App. S.D. 2014). Section 287.220.2 provides: "*If any employee who has a preexisting permanent partial disability whether from compensable injury or otherwise, of such seriousness as to constitute a hindrance or obstacle to employment or to obtaining reemployment if the employee becomes unemployed,* ... and if the employee is entitled to receive compensation on the basis of the combined disabilities, the employer at the time of the last injury shall be liable only for the degree or percentage of disability which would have resulted from the last injury had there been no preexisting disability. After the compensation liability of the employer for the last injury, considered alone, has been determined by an administrative law judge or the commission, the degree or percentage of employee's disability that is attributable to all injuries or conditions existing at the time the last injury was sustained shall then be determined by that administrative law judge or by the commission and the degree or percentage of disability which existed prior to the last injury plus the disability resulting from the last injury, if any, considered alone, shall be deducted from the combined disability, and compensation for the balance, if any, shall be paid out of a special fund known as the second injury fund." "The determination of whether a claimant is permanently and totally disabled is based upon the claimant's ability to compete in the open labor market." *Brashers v. Treasurer of State as Custodian of Second Injury Fund*, 442 S.W.3d 152, 155 (Mo. App. S.D. 2014). There is no explicit requirement that a pre-existing condition be symptomatic at the time of the subsequent, primary injury.

In *Atchison*, the employee suffered a primary injury involving a herniated disc at L4-L5 following a compensable slip and fall at work. This fall, in isolation, created a 35% permanent partial disability to the body as a whole. The employee suffered from preexisting condition including both degenerative disc and degenerative joint disease from L2-L3 through L5-S1 which was a permanent and potentially disabling medical condition. This pre-existing degenerative condition created a 65% permanent partial disability to the body as a whole. The employee was held to be permanently and totally

disabled following the work-related injury, which rendered his pre-existing condition symptomatic and severely debilitating. On appeal, the SIF acknowledged the factual findings of the ALJ and LIRC, but argued the LIRC mis-applied the law as pre-existing permanent partial disability was not symptomatic and, therefore, not compensable. The Court of Appeals found no requirement in the statute that any of the preexisting injuries be "symptomatic" prior to the primary work injury in creating SIF liability for a permanent total disability claim. The requirement is simply that the Commission must find that the combination of the last injury and the preexisting disabilities resulted in permanent total disability. In finding no requirement that pre-existing disabilities must be symptomatic at the time of the second, primary injury, the Court of Appeals upheld the award of permanent total disability against the SIF.

Atchison v. Missouri State Treasurer, 603 S.W.3d 719, 724 (Mo. App. S.D. 2020).

Q: Did an obese employee (deceased) suffering from a heat stroke while working outside suffer a compensable workers' compensation injury despite his obesity being asserted as an idiopathic condition causing his injury?

A: Yes, when there is substantial credible evidence to support working in extremely hot weather constituted an unexpected traumatic event or an unusual strain and was the prevailing factor in causing the employee's heat stroke and resulting death. *Tyler Halsey (Deceased) v. Townsend Tree Serv. Co., LLC*). The exclusion from the category of compensable injuries of an injury resulting directly or indirectly from idiopathic causes is in the nature of an affirmative defense to the employer and is not the employee's burden to prove.

In *Halsey*, the 23-year-old claimant was working outside on July 22, 2016, trimming trees and chipping and hauling brush in extreme heat. Claimant had just been hired and began working for respondent just three days prior to his accident, and previously had not worked in four years. The temperatures during the afternoon of July 22, 2016 in Poplar Bluff ranged from 111 degrees to 114 degrees Fahrenheit. While working, claimant passed out and was unresponsive. It was later determined he had a heat stroke. Claimant sadly passed away the following day while in the hospital. Claimant's preexisting conditions included morbid obesity, bipolar disorder, and psychosis. Both physicians performing autopsies on claimant opined he died of hyperthermia, or abnormally high body temperature.

The court found claimant's heat stroke was an "accident" under 287.020.2, being both "an unexpected traumatic event" and an "unusual strain identifiable by time and place of occurrence and producing at the time objective symptoms of an injury caused by a specific event during a single work shift." Medical experts testified that although claimant was extremely obese, claimant's occupational activities and the extreme heat on July 22, 2016 were the prevailing factor which caused employee's diagnosed heat stroke and ultimate death.

Interestingly, claimant's counsel argued his claim is not subject to the Missouri Workers' Compensation Act because his obesity qualifies as an idiopathic condition under 287.020.3(3), which provides "An injury resulting directly or indirectly from idiopathic causes is not compensable." The court reviewed idiopathic condition arguments from past cases. They applied the following reasoning and rule:

> [I]n order for an idiopathic condition to qualify for the current workers' compensation exception, the employee's injury must be entirely idiopathic in nature such that no other factor precipitates the injury. In other words, an idiopathic condition qualifies for the exclusion only if it exposes the individual employee to a special risk of injury that only exists because of the presence of the idiopathic condition in that employee.

Because all of the employees of respondent working in the heat on the date of accident were also suffering from heat exhaustion symptoms and were equally exposed to the possibility of heat stroke by their shared working conditions, claimant's injury did not result directly or indirectly from an idiopathic condition. Therefore, the Commission affirmed the award of compensation.

Tyler Halsey (Deceased v. Townsend Tree Serv. Co., LLC Insurer: Ace Am. Ins. Co., Injury No. 16-053905, 2020 WL 1903334 (Mo. Lab. Ind. Rel. Comm'n Apr. 9, 2020)

Q: Whether an employee grabbing the shirt of a co-worker prior to being hit multiple times in the head by that co-worker has suffered a compensable injury under the Act?

A: No. Under RSMo 287.120.1, every employer subject to the provisions of this chapter shall be liable, irrespective of negligence, to furnish compensation under the provisions of this chapter for personal injury or death of the employee by accident or occupational disease arising out of and in the course of the employee's employment. The term "accident" as used in this section shall include, but not be limited to, injury or death of the employee caused by the unprovoked violence or assault against the employee by any person. Since 1969, Section 287.120.1 has included "unprovoked assaults" within the statutory definition of "accident." The Missouri Court of Appeals has held that it logically follows that injuries from provoked assaults are not compensable. *Van Black v Trio Masonry, Inc*., 986 SW 2nd 200 (Mo. App. WD 1999).

In *Ford*, Claimant worked as a yard equipment operator for respondent for about a year prior to his alleged work-related injury. There is conflicting testimony in the record from the alleged assailant co-worker and the claimant on the specific events surrounding the physical altercation that took place on June 7, 2015. The testimony that is not contradicted by Claimant, is that both men had sat in a work truck, and that Claimant had requested to ride with his co-worker, Mr. Rhoads during their shift. Mr. Rhoads testified he didn't want to listen to claimant complain about his job, and told claimant to get out of his truck. The two employees exchanged some argumentative and explicative words. Mr. Rhoads testified, and claimant did not deny, that after they were arguing and got out of the truck, claimant grabbed Mr. Rhoads by the collar, and then Mr. Rhoads struck claimant in the head and jaw. Claimant was evaluated by several physicians with complains of dizziness and headaches, but objective findings were inconclusive of a concussion. Claimant then sought workers' compensation benefits for his injuries from the fight with his co-worker.

The Commission affirmed the ALJ's denial of benefits, finding the substantial credible evidence supported the finding that Claimant provoked Mr. Rhoads prior to the assault and fight which subsequently ensued. The LIRC affirmed the denial of benefits and upheld the rule that if an employee physically places his or her hands on another

employee prior to being injured in an assault or fight, the employee has provoked the assault and has not suffered a compensable "accident" under Section 287.120.1.

Nathan Ford v. Associated Elec. Coop. Inc. Insurer: Self-Insured, Injury No. 15-047091, 2020 WL 3130119 (Mo. Lab. Ind. Rel. Comm'n June 4, 2020).

Q. Can PPD benefits be awarded from the Second Injury Fund for injuries that occurred after January 1, 2014?

A. No. In *Cosby v. Treasurer of the State as Custodian of the Second Injury Fund,* Employee sustained a left knee injury at work in 2014 and filed a workers' compensation claim against his employer and the Second Injury Fund. Employee alleged that he was permanently and totally disabled or alternatively, permanently and partially disabled as a result of his knee injury combined with preexisting disabilities. The Missouri Supreme Court held that despite Employee's previous injuries, PPD benefits would not be awarded from the Fund for work injuries occurring after January 1, 2014. Additionally, the Court held that PTD benefits would be analyzed in the same manner as PPD benefits, meaning that the date of the last injury is the only date considered in determining if Fund liability exists.

Employee argued that § 287.220 violated due process, equal protection, and the open court's provision of the Missouri constitution. The Court held that § 287.220 does not violate the open courts provision of the constitution because the statute's failure to authorized PPD claims against the Fund does not arbitrarily deny access to Missouri courts; rather it eliminates a statutory cause of action. Employee argued that the statute violated his due process rights because the statute does not inform the public which rules govern their particular circumstances. Court ruled that Employee's due process violation argument conflated statutory ambiguity with vagueness, and therefore, failed to establish § 287.220 violates his due process rights. Finally, the Court held that the § 287.220 does not violate the equal protection clause because there was a rational basis behind the creation of the statue because the Fund was insolvent at the time the legislature amended the statute to eliminate PPD benefit claims against the fund. The Court confirmed the Commission's decision to deny PPD and PTD benefits. This decision overruled *Gattenby v. Treasure of the State of Missouri.*

Cosby v. Treasurer of State as Custodian of Second Injury Fund, SC 97317, 2019 WL 2588575 (Mo. 2019).

Notes Pages

Notes Pages

Notes Pages

Notes Pages

NEBRASKA WORKERS' COMPENSATION

I. JURISDICTION - Neb. Rev. Stat. §§ 48-106, 48-186

A. Act will apply where:
   1. Injuries occurred or occupational diseases contracted in Nebraska while in the scope and course of employment.
   2. Employer is a resident employer performing work in Nebraska who employs one or more employees in the regular trade, business, profession, or vocation of the employer.
   3. Injuries received and occupational diseases contracted outside Nebraska, unless otherwise stipulated by the parties, if—
      a. The employer was carrying on a business or industry in Nebraska; and
      b. The work the employee was doing at the time of the injury was part of or incident to the industry being carried on by employer in Nebraska.
         i. Domicile of the employer or employee and the place where the contract was entered into may be circumstances to aid in ascertaining whether the industry is located within the state.

B. The Act will not apply where:
   1. Employer is a railroad engaged in interstate or foreign commerce.
   2. The employee is a household domestic servant in a private residence.
   3. The employer is engaged in agricultural operations and employees only agricultural employees, with certain exceptions.
   4. The employee is subject to a federal workers' compensation statute.

II. PERSONAL INJURY

A. Accident – Neb. Rev. Stat. § 48-151
   1. An unexpected or unforeseen injury happening suddenly and violently, with or without human fault, and producing at the time objective symptoms of an injury.
      a. For repetitive trauma—
         i. "Unexpected or unforeseen" requirement is satisfied if either the cause was of an accidental character or the effect was unexpected or unforeseen;
         ii. "Suddenly and violently" element is satisfied if the injury occurs at an identifiable point in time requiring the employee to discontinue employment and seek medical treatment.
   2. An "injury" means violence to the physical structure of the body and such disease or infection as naturally results therefrom.
      a. Special cases—
         i. ***Heart attack*** – legal and medical causation;

(a) Legal: Court determines what kind of exertion satisfies "arising out of employment."

(b) Medical: Medical evidence establishes employee's exertion in fact caused his or her heart attack.

ii. ***Mental/Psychiatric*** – requires a physical component and medical testimony linking mental health disorder with physical injuries sustained or occupational disease contracted.

iii. ***Mental/Mental*** – requires condition causing the injury to be extraordinary or unusual when compared to the normal conditions of employment and causation established by competent medical evidence. Applies only to First Responders, ie Police, Firefighters, and EMTs.

3. An injury, to be compensable, must arise out of and in the course of the employment:

a. "Arise out of" – there must be a causal connection between the conditions under which the work was required to be performed and the resulting injury.

i. Special Cases—

(a) ***Risks to Public at Large/Acts of God***: generally not compensable unless employment duties put employee in position they might not otherwise be in which exposes them to risk, even though risk is not greater than that of general public (positional risk doctrine).

(b) ***Idiopathic cause***: non-compensable unless employment placed employee in position of increased risk.

(c) ***Horseplay***: compensable if deviation from work was insubstantial and did not measurably detracted from work.

(d) ***Assault***: injury may be compensable depending on reason for assault—

(i.) Work conditions: generally compensable.

(ii.) Personal animosity: generally not compensable.

b. "In the course of" – the injury must arise within the time and space boundaries of employment, and in the course of an activity whose purpose is related to the employment.

i. ***Coming and going:*** No recovery for injury while coming to or going from employer's workplace or jobsite. Injuries which occur on the employer's premises are generally compensable if no affirmative defenses apply.

ii. ***Exceptions***:

(a) Dual Purpose: If the employee is injured while on a trip which serves both a business and personal purpose, the injuries are compensable if the trip involves some service to the employer which would have caused the employee to go on the trip, and the employee selected a "reasonable and practical" route.

(b) Employer Created Condition: when a distinct causal connection exists between an employer-created condition and the occurrence of an injury, the injury will be compensable.

(c) Minor deviation: acts incidental to employment.

(d) Personal convenience: acts an employee may normally be expected to indulge in under the conditions of his work, if not in conflict with specific instructions, are generally compensable.

(e) Parking lot: If owned, maintained, or otherwise sponsored by employer.

(f) Employer-supplied transportation: If provided for work-related reason and not merely for employee benefit or convenience.

(g) Commercial traveler: If the employee's occupation requires that he or she travel, and there is no easily identifiable labor hub.

B. Occupational Disease – Neb. Rev. Stat. § 48-151

1. Occupational disease is a disease which is due to the causes and conditions which are characteristic of and peculiar to a particular trade, occupation, process or employment.
2. Ordinary diseases of life to which the general public is exposed outside of the employment shall not be compensable.
3. Employee "disabled", and thus eligible for compensation, when permanent medical impairment or medically assessed work restriction results in labor market access loss.
4. Date establishing employer liability is based on "last injurious exposure" or last exposure which bears a causal relationship to the disease. Employment need only be of the type which could cause the disease, given prolonged exposure.

III. NOTICE – Neb. Rev. Stat. § 48-133

A. Notice of injury is required "as soon as practicable" following the accident.

B. In repetitive trauma/occupational diseases, notice is required as soon as practicable from time employee's condition becomes an "injury."

C. The notice must be written and include the time, place and cause of the injury, except that if employee can show that employer had actual or constructive notice of the injury, no written notice is required.

D. Notice given five months after the injury is "unreasonable" per se.

IV. REPORT OF INJURY – Neb. Rev. Stat. § 48-144.01

A. FROI – First Report of Injury

1. For every Reportable Injury (including medical only injuries) arising out of and in the course of employment, a report of injury must be electronically filed with the Nebraska Workers' Compensation Court within ten days of the reportable injury.
    a. Reportable Injury means those injuries or diagnosed occupational diseases that result in:
        i. death, regardless of the time between the death and the injury or onset of disease;
        ii. time away from work;
        iii. restricted work or termination of employment;
        iv. loss of consciousness; or
        v. medical treatment other than first aid.
    b. Failure to file injury report within 10 days of accident results in tolling of statute of limitations under § 48-137 such that two year statute of limitations does not begin to run until the report is filed.
2. A First Report of Injury is required:
    a. In the event of an injury, even if liability is denied;
    b. A change is necessary to a previously filed report;
    c. A denial is made at any time;
    d. The claim has been acquired by another carrier.
3. Any employer who fails to file a report is guilty of a Class II Misdemeanor for each such failure.

B. SROI – Subsequent Report of Injury
1. in every case where a benefit payments have been made, a subsequent report of injury shall be electronically filed with the court by the employer or its insurance carrier.
2. A Subsequent Report of Injury is required when:
    a. The first indemnity payment has been made;
    b. A change is necessary to a previously filed report;
    c. A claim has been denied;
    d. Every 180 days the claim has been open
    e. Benefits have been reinstated;
    f. The claim has been closed;
    g. Jurisdiction has been changed.

V. CLAIM FOR COMPENSATION – Neb. Rev. Stat. §§ 48-137, 48-144.04

A. Employee has two years from the date of accident or the last date payment was received by the intended recipient for benefits to file a timely Petition.

B. If Employer fails to file an injury report within 10 days of accident, the two year statute of limitations does not begin to run until such report is filed.

VI. ANSWER TO PETITION – Neb. Rev. Stat. § 48-176

A. Petition served upon employer and carrier with Summons. Summons to be returned to Division within 7 days of service. Answer to Petition must be filed within 7 days of summons return to Workers' Compensation Court.

B. Failure to file timely answer may result in acceptance of facts in claim and default judgment.

VII. MEDICAL TREATMENT – Neb. Rev. Stat. § 48-120

A. Employer responsible for all reasonable medical/surgical/hospital services required by the nature of the injury, plus mileage for travel and incidental expenses necessary to obtain such services.

B. If employer does not participate in Managed Care Plan—
   1. Following injury, employer must notify employee of right to select a physician who has maintained the employee's medical records and has a documented history with the employee prior to an injury.
      a. If employer fails to notify employee, employee may choose any provider.
      b. If, after notification, employee fails to exercise the right to choose his or her provider, then employer may choose.
   2. Change of doctor only by agreement of the parties or by order of the compensation court.

C. If employer participates in Managed Care Plan—
   1. Employer must notify employee of right to select primary treating physician in accordance with above—
      a. Chosen physician, if outside Plan, must agree to the rules of the Plan; or
      b. Employee may choose among doctors already signed up with the Plan.
   2. Choice of physician rules do not apply if:
      a. Employer denies compensability;
      b. Injury involves dismemberment or major surgical operation;
      c. Employer fails to provide notice of right to select treating physician.
      d. Must be careful when answering petition for benefits. If employer denies compensability, employee may leave Plan and employer is liable for medical services previously provided.
   3. Employee may change primary treating physician within the Managed Care Plan at least once without agreement or court order.
   4. Employer, insurance carrier, or representative of the employer or insurance carrier has right to access all medical records of the employee. Failure to provide medical records may result in a Court order striking the medical provider's right to payment.
   5. Bills are paid pursuant to the Nebraska Fee Schedule.

VIII. VOCATIONAL REHABILITATION – Neb. Rev. Stat. §48-162.01

A. Employee entitled to vocational rehabilitation services if unable to perform suitable work for which he or she has previous training or experience.

B. Used to take a potential permanent total to another vocation or to reduce/eliminate loss of wage earning capacity.

C. Claimant must submit to evaluation by a vocational rehabilitation counselor who will, if necessary, develop and implement a vocational rehabilitation plan.

D. Claimant has right to accept or decline rehabilitation services, but refusal to participate in a court-approved plan, without reasonable cause, can result in penalties – vocational rehabilitation services may be terminated and compensation court may suspend, reduce, or limit compensation otherwise payable under Workers' Compensation Act.

E. Costs of vocational rehabilitation paid from Workers' Compensation Trust Fund; weekly temporary benefits and medical costs paid by employer.

IX. AVERAGE WEEKLY WAGE – Neb. Rev. Stat. §§ 48-121, 48-126

A. For continuous employments where the rate of wages was fixed by the day or hour or by the output of the employee, wage is average weekly income for the period of time ordinarily constituting his week's work, with reference to the average earnings for a working day of ordinary length, and using as much of preceding six months as was worked prior to accident. Overtime earnings excluded, unless the premium for the policy includes a charge for overtime wages.

B. Gratuity or tip and similar advantages are excluded in calculation of average weekly wage to the extent that the money value of such advantages was not fixed by the parties at the time of hiring.

C. Special Cases—
   1. ***Part-time employees***: for permanent disability only, must base average weekly wage on minimum 5-day workweek if paid by the day, minimum 40-hour workweek if paid by the hour or on whichever is higher if paid by output.
   2. ***Multiple employments***: base average weekly wage on wages of employer where accident occurred only, unless seasonal employee.
   3. ***Seasonal employment***: in occupations involving seasonal employment or employment dependent on the weather, average weekly wage is determined to be one-fiftieth of the total wages earned from all occupations during the year immediately preceding the accident.
   4. ***New employees***: where worker has insufficient work history to calculate average weekly wage, what would ordinarily constitute that employee's

average weekly income should be estimated by considering other employees working similar jobs for similar employers. Where available, such similar employees' work records should be considered for the 6-month period prior to the accident.

X. DISABILITY BENEFITS

A. Temporary Total Disability (TTD) – Neb. Rev. Stat. § 48-121(1)
   1. Compensation rate two-thirds Average Weekly Wage (AWW) up to maximum.
   2. Payable until maximum medical improvement reached, provided the employee does not secure alternative employment for the same, or a different, employer.
   3. Waiting period (Neb. Rev. Stat. § 48-119) – seven calendar days. Benefits must be paid for those seven days if claimant is disabled six or more weeks.
   4. Can be owed for scheduled as well as whole body injuries.

B. Temporary Partial Disability (TPD) – Neb. Rev. Stat. § 48-121(2)
   1. Employee able to return to work part-time while under medical care.
   2. Compensation rate two-thirds of difference between wages received at time of injury and earning power of employee afterwards, up to maximum.

C. Permanent Total Disability (PTD) – Neb. Rev. Stat. § 48-121(1)
   1. Definition: inability of the worker to perform any work which he or she has the experience or capacity to perform; workers who, while not altogether incapacitated for work, are so handicapped that they will not be employed regularly in any well-known branch of the labor market.
   2. Compensation rate two-thirds AWW up to maximum, paid for life.
   3. Law does allow lump sum settlements based on present value of permanent total award if filed with and approved by the workers' compensation court – Neb. Rev. Stat. § 48-139. Generally saves 34% of total cost of obligation.

D. Permanent Partial Disability (PPD) – Neb. Rev. Stat. § 48-121(2), (3)
   1. Definition: a disability that is permanent in nature and partial in degree.
   2. Scheduled Member Injuries – "Loss of Use"
      a. Injury to a body member – ex. Arm, leg, foot, hand, etc.
      b. Compensation rate of two-thirds AWW, up to maximum, in accordance with schedule.
         i. Nebraska favors the 5th Edition of the AMA Guidelines for Permanent Impairment, but will accept a rating pursuant to the 6th Edition of the Guidelines to assist the trier of fact. The Court is not bound by the guidelines or a rating provided by a physician.
      c. Two-member injury rule – – total loss or total permanent loss of use of two members in one accident constitutes permanent total disability.
      d. If loss of use of more than one member does not constitute permanent

total disability, compensation is paid for each member with periods of benefits running consecutively.

e. No deduction for TTD benefits paid**.**

3. Body as a Whole Injuries – "Loss of Earning Capacity"
   a. Injury to trunk of body, neck or head, but not including shoulder or injuries below the trochanteric neck of the femur.
   b. Injuries to two scheduled members from the same accident which combine to create a loss of earnings of more than thirty percent are compensated on the basis of loss of earning capacity.
   c. Compensation rate is percentage of lost earning capacity multiplied by two-thirds of AWW.
   d. Payable for 300 weeks.
   e. Deduction for weeks TTD benefits paid**.**
4. Calculation of Permanent Partial Disability
   a. Scheduled Member Injury:
      i. Claimant has a rating of 10 percent permanent partial disability to the foot, which qualifies for 150 weeks of benefits.
      ii. Claimant qualifies for maximum compensation rate for his date of accident of $644.00.
      iii. Award would be $9660.00 (150 wks X 10% X $644).
      iv. No credit for TTD paid.
   b. Body as a Whole:
      i. Claimant qualifies for maximum compensation rate for his date of accident of $644.00.
      ii. Claimant has a 50% loss of earning capacity.
      iii. Claimant received TTD benefits for 20 weeks (300 – 20 = 280 wks payable).
      iv. Award would be $90,160.00 (280 wks X $644.00 X 50%).

E. Death - Neb. Rev. Stat. § 48-122
   1. Death resulting from accident/injury.
      a. Widow(er) entitled to weekly compensation benefits for life or until remarriage.
         i. No children - rate of compensation two-thirds AWW at time of death, up to maximum.
         ii. Children - rate of compensation three-quarters AWW at time of death, up to maximum.
      b. If spouse remarries, he/she receives two years of benefits in lump sum and payments cease.
      c. Dependent children receive weekly benefits payable to children during dependency or until age 19, or age 25 if incapable of support or a full-time student at an accredited institution.
      d. Lump sum settlements are allowed if filed with and approved by the

workers' compensation court – Neb. Rev. Stat. § 48-139

e. Reasonable expenses of burial, not exceeding $10,000.00.

XI. DEFENSES

A. Statutory:

1. ***Willful Negligence*** (Neb. Rev. Stat. §§ 48-127, 48-151): employer must prove (a) a deliberate act knowingly done; (b) such conduct as evidences a reckless indifference for safety; or (c) intoxication.
   a. "Reckless indifference for safety" means more than want of ordinary care. The conduct of the employee must manifest a reckless disregard for the consequences coupled with a consciousness that injury will naturally or probably result.
   b. Intoxication:
      i. Burden on employer; must show that employee was intoxicated, either by alcohol or non-prescribed controlled substance, and that the intoxication was the cause of the accident.
      ii. Defense unavailable if employee was intoxicated with consent, knowledge, or acquiescence of employer.
2. ***Statute of Limitations*** (Neb. Rev. Stat. § 48-137): two years from date of accident or of last benefits paid, unless the injury report is not timely filed by the employer. In that case, the statute tolls the two-year limitation until the injury report is filed. Employer has 10 days from the date they are notified of the accident to file the injury report with the Workers' Compensation Court.
3. ***Timely Notice of Accident to Employer*** (Neb. Rev. Stat. § 48-133): Claimant must give written notice of the time, place, and nature of the injury as soon as practicable after the happening thereof. The Supreme Court has ruled that five months is per se unreasonable.

B. Other Defenses:

1. ***Failure to Use Provided Safety Devices***: compensable only if failure to use safety devices amounted to willful negligence.
2. ***Intoxication:*** Intoxication will bar recovery if, at the time of the injury, the Plaintiff was in a state of intoxication and the intoxication caused or contributed to the cause of the injury. The employer must not have known about the intoxication.
3. ***Violation of a Safety Rule***: An employer may prevail where the employer has:
   a. a reasonable rule designed to protect the health and safety of the employee,
   b. the employee has actual notice of the rule
   c. the employee has an understanding of the danger involved in the violation of the rule
   d. the rule is kept alive by bona fide enforcement by the employer, and
   e. the employee has no bona fide excuse for the rule violation.

4. ***Recreational Injuries:*** Generally compensable when:
   a. they occur on the premises as a regular incident of employment;
   b. the employer, by expressly or impliedly requiring participation brings the activity within the orbit of employment; or
   c. the employer derives substantial direct benefit from the activity beyond value of improvement in employee health and morale.
5. ***Independent Contractor:***
   a. "Independent Contractor" – one who, in course of independent occupation or employment, undertakes work subject to will or control of person for whom the work is done only as to result of the work and not as to methods or means used; such person is not employee within meaning of workers' compensation statutes.
      i. Exception – if the employer has created a scheme, artifice or device to enable them to execute work without providing workers' compensation coverage, then liability will be imputed to the employer.
   b. To be eligible for compensation under Workers' Compensation Act, alleged employee must prove that he or she is an "employee" in order to invoke jurisdiction of Workers' Compensation Court.

XII. PENALTIES

A. Absent a reasonable controversy, the employer or insurance carrier must pay, within thirty days, all medical and indemnity benefits due and owing to the employee and medical providers. Failure to do so will result in;
   1. A 50% penalty on all indemnity benefits due and owing, plus interest and/or;
   2. Attorney's fees and interest for securing payment of all medical expenses not timely made.

B. A reasonable controversy is;
   1. The existence of any reasonable factual dispute that, if proven true, would absolve the employer or insurance carrier of liability, or;
   2. Any unanswered question of law which bears on the outcome of compensability.

Q: Can an employer or insurance provider challenge a new Form 50 physician's treatment plan for the employee before that physician prescribes any treatment?

A: No. According to Neb. Rev. Stat. Ann. § 48-120(6), an employer may contest any future claims for medical treatment on the basis that such treatment is unrelated to the original work-related injury or occupational disease, or that the treatment is unnecessary or inapplicable. This statute is only applicable when contesting treatment already prescribed by a current Form 50 physician.

In *Rogers*, employee, Sheryl Rogers, was being treated by a Nebraska physician who prescribed opioid treatment in 2001. Appellant-employer, Jack's Supper Club, and Nebraska Worker's Compensation Court (WCC) expressed concerns about this type of treatment. In 2010, Rogers moved to Florida where she began seeing Dr. Daitch, a Florida physician. Rogers told Jack's that Daitch was her new Form 50 physician. Jack's stopped paying for her medical treatment, saying that she could not unilaterally change her Form 50 physician according to Neb. Rev. Stat. Ann. § 48-120. Rogers filed a motion to compel, and Jack's added a claim saying that Roger's opioid treatment was unnecessary medical care.

The WCC mentioned that the change in physicians was warranted due to location change, but Nebraska Supreme Court reversed and remanded with directions telling the WCC that they must make an explicit statement that the physician change is "desirable or necessary" pursuant to Neb. Rev. Stat. Ann. § 48-120. The lower court followed said directions to designate Daitch as the new Form 50 physician, and Jack's appealed stating that the WCC failed to address whether Roger's opioid treatment was necessary. The Nebraska Supreme Court held that since Dr. Daitch, the new Form 50 physician, had not prescribed any opioid treatment, that claim was purely speculatory, and it relied on Daitch prescribing opioids in the future. Here, a claim under Neb. Rev. Stat. Ann. § 48-120(6) could be brought unless a controversy exists after Dr. Daitch was appointed as the Form 50 physician and made treatment recommendations.

Rogers v. Jack's Supper Club, 308 Neb. 107, 953 N.W.2d 9 (2021).

Q: Is claimant-employee entitled to award of penalties and attorney fees if reasonable controversy exists as to compensability of claim and nature and extent of injuries?

A: No. Neb. Rev. Stat. Ann. § 48-125 provides for a waiting-time penalty and attorney fees when the employer fails to pay compensation within 30 days of notice of disability so long as no reasonable controversy exists.

In *Boring*, employee Martin Boring filed a petition in the Nebraska WCC against Zoetis LLC in 2018. He claimed a compensable injury arising out of his employment with Zoetis, and he claimed that Zoetis refused to make payments of compensable medical and mileage expenses. In 2020, the WCC awarded Boring temporary and permanent

benefits, and it ordered Zoetis to pay penalties and attorney fees. The WCC claimed that Zoetis admitted in its answer that Boring sustained a work accident and injuries arising out of course of employment and that this admission entitled Boring to penalties and attorney fees under Neb. Rev. Stat. Ann. § 48-125. Zoetis appealed to the Nebraska Court of Appeals, which affirmed the benefits, but reversed and vacated the award of penalties and attorney fees on the ground that there was reasonable controversy as to the nature and extent of the injury.

The Court of Appeals of Nebraska reasoned that Zoetis' admission constituted only an admission to some accident suffered by Boring on the day of injury. In its answer, Zoetis disputed the nature and extent of that injury and the benefits attributable thereto. The Court of Appeals held that penalties and attorney fees awarded under Neb. Rev. Stat. Ann. § 48-125 may only be awarded when no reasonable controversy exists. The court found that Zoetis most certainly denied the nature and extent of Boring's injuries. Here, the Nebraska Supreme Court affirmed the lower court's decision but added a few points. They mentioned that Neb. Rev. Stat. Ann. § 48-125(3) does not authorize penalties for delinquent payment of medical expenses. Also, the WCC erred when it failed to examine the trial evidence to determine whether there was a reasonable controversy. The WCC is not bound by formal rules of procedure, meaning here that although one party may have made a judicial admission, the opposing party did not take advantage of said admission at trial and therefore was not relieved of the burden of producing evidence in support of his allegation.

Here, although Zoetis admitted that Boring suffered an accident in scope of employment, a reasonable controversy regarding nature and extent of injury still existed, therefore, penalties and attorney fees under Neb. Rev. Stat. Ann. § 48-125 were not permitted.

Boring v. Zoetis LLC, 309 Neb. 270 (2021).

Q: (1) Can a claimant-employee who received an amputation below the left knee be awarded consecutive amounts of disability benefits for the loss of five toes, left foot, and total loss of left leg? (2) Whether penalties were owed for PPD for amputations paid after a plaintiff reaches MMI rather than when TTD was discontinued?

A: (1) No. According to Neb. Rev. Stat. Ann. § 48-121(3), a below-the-knee amputation is the equivalent of a loss of a foot only. Citing to *D'Quaix v. Chadron State College,* 272 Neb. 859, 725 N.W.2d 183 (2020), the Court noted the general rule is that a party may not have double recovery for a single injury.

A: (2) No. A 50% penalty payment for waiting time involving delinquent payment of compensation is only appropriate when no reasonable controversy exists. Neb. Rev. Stat. Ann. § 48-125.

The Nebraska Supreme Court noted that they "have not ruled that the discontinuance of temporary disability payments triggers payment of permanent disability payments in a case involving amputation." Therefore, the question of when PPD must be paid for amputations was a reasonable controversy precluding penalties.

In *Melton*, employee Benjamin Melton sought workers' compensation benefits after an injury in 2011 resulted in a below-the-knee amputation of his leg. In 2017, Melton reached MMI and the City of Holdrege paid permanent partial disability based on 100% loss of Melton's foot and an additional 5% loss to his leg. Melton then sought an additional award for the loss of each toe on his left foot in addition to the loss of that foot. The trial court awarded him compensation for a loss of foot and a partial loss of leg function. Melton argued that the court erred by failing to award a waiting-time penalty, interest, and attorney's fees with respect to late payment of permanent disability benefits for the loss of his foot. Based on his position, his disability was reasonably ascertainable at the time of amputation and therefore PPD should have been paid as soon as TTD was discontinued before he reached MMI.

The Court of Appeals of Nebraska held that Melton had not lost all functional use of his left leg, but that loss of thigh strength and atrophy combined with knee pain have reduced the function of his leg beyond the loss of his foot (20% loss of function). The court refuted Melton's argument for payment of consecutive amounts of disability benefits for five toes, left foot, and left leg. Neb. Rev. Stat. Ann. § 48-121(3) holds that a below-the-knee amputation is the equivalent of a loss of a foot only. Therefore, the court appropriately compensated Melton for the functional loss of his leg. The Court of Appeals of Nebraska also held that 50% penalty payment for waiting time was not appropriate here because there was reasonable controversy surrounding payment of PPD for amputations when temporary disability benefits were discontinued before reaching MMI. Neb. Rev. Stat. Ann. § 48-125.

The Nebraska Supreme Court noted that because there has not been a ruling that discontinuance of temporary disability payments triggers payment of permanent disability before MMI in cases of amputation, the question regarding discontinuance of temporary disability payments is a reasonable controversy that remains unanswered. The Court did not make a finding as to whether PPD for amputations should be paid when TTD is discontinued, but only that the issue had not previously been determined by the Nebraska Supreme Court to support an award of penalties.

Melton v. City of Holdrege, 309 Neb. 385 (2021).

Q: Is a contractor who hired an independent contractor obligated to provide workers' compensation benefits for that independent contractor if they are hurt?

A: No. A contractor who hired an independent contractor is not liable for an injury sustained by that independent contractor.

The court will consider several factors to determine if an injured worker is an employee or an independent contractor, to include: (1) the extent of control which, by the agreement, the employer may exercise over the details of the work; (2) whether the one employed is engaged in a distinct occupation or business; (3) the kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of the employer or by a specialist without supervision; (4) the skill required in the particular occupation; (5) whether the employer or the one employed supplies the instrumentalities, tools, and the place of work for the person doing the work; (6)

the length of time for which the one employed is engaged; (7) the method of payment, whether by the time or by the job; (8) whether the work is part of the regular business of the employer; (9) whether the parties believe they are creating an agency relationship; and (10) whether the employer is or is not in business.

In Wright, the plaintiff's estate alleged plaintiff was an employee of defendant's and requested workers' compensation benefits. Defendants denied the claim asserting plaintiff was an independent contractor and provided the court with several factors which confirmed the same. Evidence presented explained plaintiff owned his own company; plaintiff performed jobs for defendant intermittently for several years; defendant invoiced plaintiff for projects completed; plaintiff was paid per job; defendant issued 1099 tax forms to plaintiff and never a W2 form; plaintiff was free to turn down any job from defendant – which he had done periodically; plaintiff operated his own checking account and filed tax returns to which he deducted substantial business expenses including vehicles, contract labor and insurance from; plaintiff indicated on his tax returns he was an independent contractor and plaintiff was urged by his insurance agent to purchase workers' compensation insurance but never did and instead carried general liability insurance. For these reasons the Court of Appeals found plaintiff was not an employee of defendant and dismissed the petition.

Wright v. H & S Contracting, Inc., 29 Neb. App. 581, 581–82 (2021).

Q: Is suicide, or intentional injury, a compensable injury?

A: No. According to Neb. Rev. Stat § 48-101 suicide and intentional injuries are generally willful negligence and thus not compensable injuries under workers' compensation.

In *Eddy*, employee alleged a workers' compensation injury after she accidently shot herself in the head with a nail gun. Defendants denied the claim alleging she intentionally injured herself. The lower court excluded employee's expert's testimony and ultimately dismissed her petition after concluding she did intentionally shoot herself in the head with a nail gun. The Supreme Court determined the employee's claim was properly dismissed according to Neb. Rev. Stat § 48-101 because intentional injuries and suicide are generally considered willful negligence which is an affirmative defense in workers' compensation.

Eddy v. Builders Supply Co., 304 Neb. 804, 937 N.W.2d 198 (2020).

Q: Does Nebraska allow for apportionment of impairment or disability in cases of successive injuries?

A: Probably not in cases of scheduled injury and functional impairment, but the assessment of loss of earning power in cases of whole-body injury on a second claim does take into consideration the effect of a prior loss of earning power.

In *Picard*, employee sustained two successive injuries while working for the same employer. The two claims were consolidated for entry of a single award.

She first suffered bilateral carpal tunnel syndrome in 2012 and was given permanent restrictions that included no lifting greater than five pounds. The trial court and Court of Appeals found that compensation premised upon impairment ratings for each upper

extremity did not adequately compensate the employee for the 2012 injury and awarded compensation for a 75% loss of earning power.

The employee returned to accommodated work for the employer and then sustained a second injury to her low back which resulted in the assignment of restrictions on bending and no lifting greater than ten pounds. The trial court and Court of Appeals found that in isolation the second injury resulted in a 55% loss of earning power. The employee was granted compensation for the full value of the 55% loss of earning power, in addition the full value of the first determination of a 75% loss of earning power.

The trial court and Court of Appeals found that there is no apportionment in Nebraska for prior injury and that the employee was entitled to a determination of loss of earning power for the effect of the 2015 injury without consideration of the effect of the 2012 injury.

The Nebraska Supreme Court accepted the employer's appeal and tried to clarify what it viewed as inconsistent prior decisions regarding apportionment in Nebraska. It noted the history of apportionment in Nebraska that concluded with a 1983 statutory amendment that brought an end to the Second Injury Fund for injuries sustained after December 1, 1997. There is no statute in Nebraska granting apportionment for injury sustained after December 1, 1997. In the absence of such a statute, the Court concluded that the "full-responsibility rule" applies, under which the employer is generally held liable for the entire disability determined appropriate for a successive injury.

Having determined apportionment does not exist in Nebraska, it certainly seemed as though the Supreme Court would affirm the decision of the Court of Appeals and grant the employee compensation for the full findings of loss of earning power on both claims.

It was at that point in the decision, however, that the Supreme Court took an odd turn. It noted that the employee returned to work for the employer again without further accommodation after the 2015 injury and was then earning a wage higher than was being earned at the time of the 2015 injury. It noted that the Court of Appeals found the employee had not sustained a loss of earning power because of the 2015 injury if consideration was given to the effect of the 2012 injury.

The Supreme Court then found that the effect of the 2012 injury was to be taken into consideration when determining loss of earning power after the 2015 injury. Doing so resulted in a finding of no loss of earning power because of the 2015 injury. The award of compensation for a 55% loss of earning power on the 2015 injury was reversed, resulting in no permanent partial disability compensation for that injury.

The Supreme Court offered no comment on what this means for apportionment in cases of successive scheduled injuries where impairment is based upon a doctor's functional impairment rating, but it appears in those cases the Court would apply the "full-responsibility rule" so that the employee is entitled to compensation for the full value of an impairment rating assigned after a successive injury.

Picard v. P & C Grp. 1, Inc., 306 Neb. 292, 308, 945 N.W.2d 183, 197 (2020).

Q: Can a principal contractor be liable for conducting a scheme to avoid workers' compensation when it fails to require its subcontractors to carry workers' compensation insurance and subsequently an independent contractor of that subcontractor sustains a job-related injury?

A: No. Liability for conducting a scheme to avoid workers' compensation under Neb. Rev. Stat. Ann. § 48-116 may be avoided if the injured worker is deemed an independent contractor, rather than an employee of the subcontractor.

If a principal contractor fails to require its subcontractor to carry workers' compensation insurance and an employee of the subcontractor sustains a job-related injury, the principal contractor is considered the statutory employer of the injured worker. However, such protections do not arise when the injured worker is an independent contractor, rather than an employee of the subcontractor.

The court noted that the purpose of § 48-116 is to ensure that companies cannot use subcontractors to absolve them of the responsibility to ensure that employees are properly insured under the Nebraska Workers' Compensation Act. The court then states that prior case law and the language of the statue make it clear that protections under § 48-116 presuppose the injured worker to be an employee of the subcontractor.

Aboytes-Mosqueda v. LFA Inc., 306 Neb. 277 (2020).

Q: Is the attorney-client agreement required to be submitted as evidence for purposes of recovering statutory attorney's fees in workers' compensation claims?

A: No. The court in *Sellers v. Reefer Sys., Inc.* held that details of the attorney-client agreement are not a necessary component of the affidavit submitted pursuant to § 2-109(F) for justification of appellate attorney fees under § 48-125(4)(b).

The Legislature determined (as a matter of public policy) that attorney fees under § 48-125(4)(b) do not depend on the terms of any fee agreement, the affidavit submitted does not need to set forth the terms (or even the existence of) a fee contract in order to justify statutorily mandated "reasonable attorney's fees". Sufficient justification for attorney's fees is determined by the nature of the litigation, the time and labor required, the novelty and difficulty of the questions raised, the skill required to properly conduct the case, the responsibility assumed, the care and diligence exhibited, the result of the suit, the character and standing of the attorney, the customary charges of the bar for similar services, and the general equities of the case.

In *Sellers*, the attorney's affidavit included the number of hours worked, the applicable rate, and the tasks performed. An expert opinion found that the hours worked and rate were reasonable. The Court found this sufficient, stating that the affidavit did not need to set forth a detailed log of all tasks performed with the amount of time spent on each task to be considered in determining reasonable attorney's fees. The court went further and stated that a court may find the fees reasonable based on "the courts general experience in matters of litigation and what has been produced by the attorney for the appellate court's direct consumption".

Sellers v. Reefer Sys., Inc., 305 Neb. 868, 870, 943 N.W.2d 275, 278 (2020).

Q: Is an order of disapproval upon an application for approval of lump-sum settlement a final appealable order?

A: No. An "order of disapproval" is not an option available to a compensation court in disapproving an application for approval of a lump-sum settlement, and therefore does not constitute a final, appealable order.

In *Loyd v. Family Dollar Stores of Nebraska, Inc.*, plaintiff's attorney objected to the court's request that the Application for Lump Sum Settlement provide the amount of attorneys' fees and costs paid from the settlement. Therefore, the compensation court entered an order of disapproval of the lump sum settlement. In not approving an application for approval of a lump-sum settlement, the court has only two options, which are exercised at the discretion of the compensation court: (1) either dismiss the application at the cost of the employer or (2) continue the hearing, none of which was done here. The Nebraska Supreme Court found that an order of disapproval does not impact the subject matter of the proceeding or prevent the party from submitting another application for approval and therefore is not a final appealable order.

Loyd v. Family Dollar Stores of Nebraska, Inc., 304 Neb. 883, 937 N.W.2d 487 (2020).

Q: Does a sole proprietor have absolute discretion in defining the scope of his or her employment for purposes of determining whether an injury arose out of employment?

A: No. In order for an injury to arise out of his or her employment, even for sole proprietors, the applicable test remains "whether the act is reasonably incident thereto or is so substantial a deviation as to constitute a break in the employment which creates a formidable independent hazard".

In *Webber v. Webber*, Webber was the sole proprietor of a moving company who injured himself by setting off a firework in a warehouse he was in for work-related purposes. Webber argued that he used fireworks to establish rapport with people with whom he worked, and that because he was the sole proprietor of his company that he determined the scope of his own employment. While the court considers Webber's own description of his job, it does not seem to resolve the issue on that basis. The court found that lighting the firework, despite Webber's ownership of the sole proprietorship, "simply cannot be categorized as a matter of personal convenience and comfort, a matter of necessity, or a beneficial interest to the employer. . ." and therefore did not arise within his employment.

Further, while the court did not determine with precision what discretion a sole proprietor has in defining the scope of his or her employment, it did decline to accept Webber's horseplay argument and affirmed the dismissal of his petition.

Webber v. Webber, 28 Neb. App. 287 (2020).

Q: Is a repetitive trauma required to materialize at an identifiable point in time to be compensable?

A: Yes. Repetitive trauma injury is compensable when claimant's repetitive trauma injury has the requisite suddenness to be an accident under Workers' Compensation Act. The cause of the injury must have been limited in time or materialized at an identifiable point in time. Neb. Rev. Stat. § 48-151(2). A workers' compensation claimant establishes an identifiable point in time when he both discontinues work and seeks medical treatment; it does not matter how long the discontinuation of employment lasts.

In *Martinez*, claimant's repetitive trauma injury to the right shoulder materialized at an identifiable point in time and thus had the requisite suddenness to be a compensable injury. Claimant felt sharp pain in shoulder which then locked up on November 8, 2017. He returned to work the next day, informed his supervisor that he could not work and was taken to the doctor. After the doctor's appointment on November 9, he was placed on light duty and did not use his right arm.

Because Martinez discontinued his employment and sought medical treatment for his right shoulder on November 9, his repetitive trauma injury materialized at an identifiable point in time and was compensable.

Martinez v. Int'l Paper Co., 27 Neb. App. 933, 937 N.W.2d 875 (2020), review denied (Mar. 11, 2020).

Q: How is the Average Weekly Wage calculated when the claimant is both an employee and a shareholder of a subchapter S corporation?

A: Net profits or net income of a subchapter S corporation do not necessarily qualify as "wages". The determination of "wages" under Neb. Rev. Stat. § 48-126 (Reissue 2010) for an employee-shareholder of a subchapter S corporation is a fact-specific inquiry.

In *Bortolotti*, the claimant sought workers' compensation benefits for injuries received before and after he became president and sole stockholder of the employer that was a subchapter S corporation. The compensation court had difficulty determining claimant's average weekly wage due to a lack of exhibits. Based on an allegation in a superseded pleading, the court held that his average weekly wage was $1,399.45, entitling him to the maximum compensation rate of $728 per week, as opposed to $49 based solely on his reported self-employment wages. The employer appealed.

The Supreme Court held that as a matter of first impression, net profits of a subchapter S corporation are not included as wages in determining the average weekly wage of an employee-shareholder. Further, "Wages" under the Workers' Compensation Act do not include payments received solely because of the recipient's status as an S corporation shareholder; rather, "wages" are compensation for the recipient's activities as a corporate employee. (Neb. Rev. Stat. § 48-126). Therefore, the claimant was required to provide evidence differentiating his wages as a corporate employee form his profits as a shareholder. The claimant failed to show this, so the court found in favor of the employer and the claimant's average weekly wage benefit was reduced.

Bortolotti v. Universal Terrazzo & Tile Co., 304 Neb. 219, 933 N.W.2d 851 (2019)

Q: What standard does the court apply when determining whether or not a claimant reported their injury "as soon as practicable".

A: The question is not about how many days, weeks, or months elapse from the time of the injury until the reporting date, but whether the claimant reported the injury "as soon as practicable" under the specific facts and circumstances of the case.

In *Bauer*, the claimant filed a claim for benefits against Genesis Healthcare Group (Genesis), concerning a shoulder injury he experienced while working as a physical therapy assistant. A trial judge of the Workers' Compensation Court determined that Bauer failed to give the required notice of injury to Genesis "as soon as practicable" after the occurrence and dismissed Bauer's petition. More specifically, the claimant initially felt pain in his shoulder on September 15, 2017 while assisting a patient in a wheelchair. Rather than see a physician he decided to engage in self-treatment activities to rehabilitate himself, placed himself on a limited work schedule, and was being "head headed" as he testified. He did not see a physician until October 20, 2017. He reported the injury on October 23, 2017.

In this case, the court found that the circumstances surrounding the claimant's first realization of his symptoms demonstrated that he did not report the injury "as soon as practicable". Specifically, the claimant was an experienced physical therapy assistant, he perceived an immediate injury to his shoulder while working, he attributed significant pain and numbness from it, he canceled weekend plans to treat it, he attempted to personally rehabilitate it, and he changed his work schedule to accommodate it. Based on these factors the court deemed that the claimant failed to report his injury "as soon as practicable".

Therefore, when determining whether an injury was reported "as soon as practicable", it is important to gather as many facts about when the claimant first noticed pain symptoms and how they handled those symptoms.

Bauer v. Genesis Healthcare Grp., 27 Neb. App. 904, 905, 937 N.W.2d 492, 493 (2019), review denied (Feb. 19, 2020)

Q: Can an insurance broker be held liable for not advising an employer of its workers' compensation obligations?

A: No. The Workers' Compensation Act governs employers, not insurance agents. (Neb. Rev. Stat. § 48-106). Absent evidence that an insurance agent or broker has agreed to provide advice or the insured was reasonably led by the agent to believe he would receive advice, the failure to volunteer information does not constitute either negligence or breach of contract for which an insurance agent or broker must answer in damages.

In *Merrick*, the claimant brought action against his employer's insurance broker and commercial lines insurer after settling his action against employer arising from work-related truck accident, alleging that the broker was negligent in failing to advise employer of obligations under the Workers' Compensation Act and that the insurer acted in bad faith in denying a defense in the underlying suit. The District Court granted summary judgment for the broker and insurer, and the claimant appealed.

The Supreme Court upheld the lower court's decision, holding that the insurer did not have a duty to advise the employer of its workers compensation obligations. Absent evidence that an insurance agent or broker has agreed to provide advice or the insured was reasonably led by the agent to believe he would receive advice, the failure to volunteer information does not constitute either negligence or breach of contract for which an insurance agent or broker must answer in damages.

Merrick v. Fischer, Rounds & Assocs., Inc., 305 Neb. 230, 939 N.W.2d 795 (2020)

Notes Pages

Notes Pages

Notes Pages

Notes Pages

OKLAHOMA WORKERS' COMPENSATION

FOR ACCIDENTS OCCURRING ON OR AFTER 5/28/2019

I. JURISDICTION – (85A O.S. § 3)

A. Act will apply where:

1. Injuries received and occupational diseases contracted in Oklahoma.
2. Contract of employment made in Oklahoma and employee was acting in the course of such employment under the discretion of the employer.
3. Claimant may not receive workers' compensation benefits in Oklahoma if claimant filed a claim in another jurisdiction unless the WCC determines there is a change of circumstances that create a good cause. Claimant cannot receive duplicate benefits. Oklahoma time limitations still apply per Section 69.

II. ACCIDENTS - (85A O.S. § 2):

A. Compensable Injury:

1. Compensable injury is defined as damage or harm to the physical structure of the body or prosthetic appliance including eyeglasses, contact lenses or hearing aids of which the major cause is either accidental, cumulative trauma or occupational disease arising out of the course and scope of the employment.
2. The accident should be unintended, unanticipated, unforeseen, unplanned and unexpected; occur at a specifically identifiable time and place; occur by chance from unknown cause; is independent of sickness, mental incapacity, body infirmity or other cause.
3. Compensable injury shall be established by objective medical evidence.
4. An employee has to prove by a preponderance of the evidence that he or she suffered a compensable injury.
5. Benefits shall not be payable for condition which results from a non-work-related independent intervening cause following a compensable injury which prolongs disability, aggravation or requires treatment.

B. Consequential injury:

1. Injury or harm to a part of the body that is a direct result of the injury or medical treatment to the body part originally injured in the claim.

C. Cumulative trauma:

1. The combined effect of repetitive physical activities expending over a period of time in the course and scope of claimant's employment. Cumulative trauma shall have resulted directly and independently of all other causes. There is no minimum time of employment or injurious exposure requirement for a compensable injury.

III. NOTICE - (85A O.S. §§ 67-68):

A. Cumulative Trauma and Occupational Disease Notice:
   1. Written notice must be given to the employer of occupational disease or cumulative trauma by the employee within six months after first distinct manifestation of disease or cumulative trauma or within six month after death.

B. Single Event Notice:
   1. Unless an employee gives oral or written notice to the employer within 30 days of the date the injury occurs, there will be a rebuttable presumption that the injury is not work related.

C. Rebuttable Presumption:
   1. Unless an employee gives oral or written notice to the employer within 30 days of the employee's separation from employment, there is a rebuttable presumption that the occupational disease or cumulative trauma did not arise out of or in the course of the employment.

IV. EMPLOYER'S NOTICE TO THE COMMISSION (85A O.S. § 63):

A. Within ten days of the date of receipt of notice or knowledge of injury or death, the employer must send the Commission a report providing factual information regarding the parties and injury.
   1. CC – FORM 2

V. CLAIM FOR COMPENSATION – (85A O.S. § 111(A)):

A. Any claim for any benefit under this act is commenced with the filing of an Employee's First Notice of Claim for Compensation by the employee with the Workers' Compensation Commission.
   1. CC – FORM 3

VI. EMPLOYER'S ACCEPTANCE OR CONTROVERSION OF CLAIM – (85A O.S. § 111(B)):

A. If an employer controverts any issue related to the Employee's First Notice of Claim for Compensation, the employer must file a Notice of Contested Issues on a form prescribed by the Commission.
   1. CC – FORM 2A – Filing of the Form 2A is no longer mandatory

VII. MEDICAL TREATMENT - (85A O.S. § 50):

A. The employer has the right to choose the treating physician.

B. If the employer fails or neglects to provide medical treatment within five days after actual knowledge is received of the injury, the employee may select the treating physician at the expense of the employer.

C. Diagnostic testing shall not be performed shorter than six months from the date of the last test without good cause shown.

D. Unless recommended by a treating physician or an independent medical examiner, continued medical maintenance should not be awarded by the Commission.

E. An employee claiming benefits under this Act shall submit him/herself to medical examination, otherwise rights and benefits shall be suspended.

F. Mileage is reimbursed to the claimant for mileage in excess of 20 miles not to exceed 600 miles.

G. Payment for medical care as required by this Act is due within 45 days of receipt by the employer or insurance carrier of a completed and accurate invoice unless there is a good faith reason to request additional information. Thereafter, the Commission may assess a penalty of up to 25% of any amount due under the fee schedule that remains unpaid on the finding by Commission that no good faith existed for the delay. A pattern of willfully and knowingly delaying payments can result in a civil penalty of not more than $5,000.00.

H. If an employee misses a scheduled appointment with a physician, the employer‘s insurance company shall pay the physician a reasonable charge determined by the Commission for the missed appointment. In absence of a good faith reason for missing the appointment, the Commission shall have the employee reimburse the employer and insurance carrier.

VIII. VOCATIONAL REHABILITATION – (85A O.S. § 45):

A. An injured employee who is eligible for permanent partial disability under this section is entitled to receive vocational rehabilitation services. Vocational rehabilitation services and training shall not exceed a period of 52 weeks.

B. On application of either party or by order of an ALJ the Vocational Rehabilitation Director shall assist the Commission to determine if a claimant is appropriate to receive vocational rehabilitation services. If appropriate, the ALJ can refer the employee for an evaluation. The cost of evaluation shall be paid by the employer. If following the evaluation, the employee refuses services, or training ordered by the ALJ or fails to make a good faith attempt in vocational rehabilitation, the cost of the evaluation and services or training may, in the discretion of the ALJ, be deducted from any remaining PPD award.

C. Request for vocational services must be filed within 60 days of permanent restrictions.

D. If retraining requires residence away from employee’s residence, reasonable room, board, tuition and books shall be paid.

E. If the employee is actively and in good faith participating in a retraining program to determine permanent total disability, he may be entitled to 52 weeks of temporary total disability benefits, plus all tuition and vocational services. The employer or employer’s insurance carrier may deduct the amount paid in tuition from compensation awarded to the employee.

IX. AVERAGE WEEKLY WAGE – (85A O.S. 59):

A. Average weekly wage is determined by dividing the gross wages by the number of weeks of employment for maximum of 52 weeks.

B. If an injured employee works for wages by the job, the average weekly wage is determined by dividing the earnings of the employee by the number of hours required to earn the wage, then multiplying the hourly rate by the number of hours in a full time work week for employment.

X. DISABILITY BENEFITS

A. Temporary Total Disability (85A O.S. § 45/ §62) If the injured worker is temporarily unable to perform his job or any alternative work, he is entitled to receive compensation equal to 70% of his average weekly wage.

1. Maximum TTD is 156 weeks.
2. TTD is not paid for the first three days of the initial period of TTD.
3. TTD shall not exceed 8 weeks for nonsurgical soft tissue injuries regardless of the number of body parts.
    a. If a claimant receives an injection or injections, they should be entitled to additional 8 weeks of TTD.
    b. Injection shall not include facet injections or IV injections.
4. If there is a surgical recommendation the injured employee can be entitled to an additional 16 weeks of TTD. If the surgery is not performed within 30 days of approval by the employer's insurance carrier and the delay is caused by the employee acting in bad faith, the benefits for the extended period shall be terminated and reimbursed all TTD beyond 8 weeks.
5. Soft tissue includes but is not limited to sprains, strains, contusion, tendinitis and muscle tears, cumulative trauma is considered soft tissue unless corrective surgery is necessary.
    a. Soft tissue does not include injury or disease to the spine, disks, nerves or spinal cord where corrective surgery is performed, many brain or closed head injuries as evidenced by sensory or motor disturbance, communication disturbance, disturbances of cerebral function, neurological disorders or other brain and closed head injuries at least as severe in nature as above, and any joint replacement.
6. If the Administrative Law Judge finds a consequential injury, the claimant may receive an additional period of 52 weeks of TTD; such finding shall be by clear and convincing evidence.
7. If the employee is released by the treating physician for all body parts, misses three consecutive medical treatment appointments without valid excuse, fails to comply with medical orders of the treating physician or abandons care, the employer may terminate TTD by giving notice to the employee or their counsel.

8. If employee objects to determination of TTD, the Commission shall set a hearing within 20 days to determine if TTD should be reinstated.
9. If otherwise qualified according to the provisions of this act, PTD benefits may be awarded to an employee who has exhausted the maximum TTD even though the employee has not reached MMI.
10. Benefits under this subsection shall be permanently terminated by order of the Commission if the employee is noncompliant or abandons treatment for sixty (60) days, or if benefits under this subsection have been suspended under this paragraph at least two times.
11. An employee who is incarcerated shall not be eligible to receive temporary total disability benefits under this title. Any medical benefits available to an incarcerated employee shall be limited by other provisions of this title in the same manner as for all injured employees.

B. Temporary partial disability (85A O.S. § 45):
   1. If claimant is only able to work part-time, he can receive the greater of 70% of the difference between the pre-injury average weekly wage and the weekly wage for performing alternative work but only if his or her weekly wage in performing the alternative work is less than the TTD rate.
   2. If the employee refuses alternative work, they are not entitled to temporary total or temporary partial disability benefits.
   3. TPD benefits are limited to 52 weeks.

C. Permanent Partial Disability (85A O.S. § 45-46):
   1. Permanent Partial Disability may not exceed 100% to the body part or body as a whole. (The language indicating that surgical body parts are not included is no longer in the Workers' Compensation Act)
   2. A physician's opinion of the nature and extent of permanent partial disability benefits to parts of the body other than scheduled members, must be based solely on criteria established under the 6th edition of the AMA Guides. All parties may submit a report from an evaluating physician.
   3. Permanent disability should not be allowed to a body part for which no medical treatment has been received.
   4. Permanent partial disability shall be 70% of the average weekly wage, not to exceed $350.00 per week. PPD shall increase to Three Hundred Sixty Dollars ($360.00) per week on July 1, 2021.
   5. Maximum permanent disability is 360 weeks to the body as a whole.
   6. In the event there exists a previous PPD, including non-work related injury or condition which produces PPD and the same is aggravated or accelerated by an accidental personal injury or occupational disease, compensation for PPD shall be only for such amount as was caused by such accidental personal injury or occupations disease and no additional compensation shall be allowed for the pre-existing PPD or impairment.
   7. An employee cannot receive payment on two permanent partial disability orders at the same time.

8. Permanent partial disability for amputation or permanent total loss of a scheduled member shall be paid regardless of whether or not claimant returns to work in his/her pre-injury or equivalent job.

D. Permanent Total Disability (85A O.S. § 45):
   1. 70% of the average weekly wage not to exceed the maximum TTD rate for the DOA.
   2. Benefits are payable until claimant reaches the age maximum of social security retirement benefits or for period of 15 years whichever is longer.
   3. If claimant dies of causes unrelated to the injury or illness, benefits cease on the date of death.
   4. Any person entitled to revive the claim shall receive a one time lump sum payment equal to 26 weeks of permanent total disability benefits.
   5. In the event the Commission awards both permanent partial disability and permanent total disability, permanent total disability does not start until permanent partial disability benefits have been paid in full.
   6. Permanent total disability benefits may be awarded to an employee who has exhausted the maximum period of temporary total disability even thought the employee has not reached MMI.
   7. The Commission shall annually review the status of an employee receiving permanent total disability benefits against the last employer and shall require the employee to file an affidavit noting that he/she has not returned to gainful employment and is not able to return to gainful employment. Failure to file the affidavit shall result in suspension of benefits which can be reinstated.
   8. Benefits for a single event injury are determined by the law in effect at the time of the injury. Benefits for cumulative trauma or occupational disease or illness are determined by the law in effect at the time the employee knew or reasonably should have known of the injury. Benefits for death are determined at the time of death.

E. Disfigurement (85A O.S. § 45):
   1. Maximum disfigurement is $50,000.00.
   2. No award for disfigurement shall be entered until 12 months from the injury unless the treating physician deems the wound or incision to be fully healed.

F. Revivor of PPD(85A O.S.§71 (E)): No compensation for disability of an injured employee shall be payable for any period beyond his or her death; provided, however if an injured employee is awarded compensation for permanent partial disability by final order and then dies, a reviver action may be brought by the injured employee's spouse, child or children under disability as defined in Section 67 but limited to the number of weeks of disability awarded to the injured employee minus the number of weeks of benefits paid for the PPD to the injured worker at the time of the death of the injured employee. An award of compensation for PPD may be made after the death of the injured employee. Such reviver action may be brought only by the injured employee's spouse, minor child or children under Section 67.

XI. DEATH BENEFITS - (85A O.S. § 47):

A. If death does not arise within one year from the date of accident or within the first three years of the period for compensation payments fixed by the compensation judgment, a rebuttable presumption shall arise that the that the death did not result from the injury.

B. A Common law spouse shall not be entitled to benefits unless he/she obtains an order form the Commission ruling that a common-law marriage existed. The Commission's ruling shall be exclusive regardless of any district court decision.

C. A surviving spouse is entitled to a lump sum payment of $100,000.00, weekly checks at 70% of the average weekly wage, and a 2-year indemnity benefit upon remarriage.

D. Children get $25,000.00 lump sum and 15% of the average weekly wage up to two children. If more than two children they divide $50,000.00 equally, and split 30% of the average weekly wage equally. If there are children but no surviving spouse, each child $25,000.00 and 50% of the average weekly wage to each child. I more than two children, this is split equally, not to exceed $150,000.00 maximum lump sum benefit.

E. Funeral expenses shall not exceed $10,000.00.

XII. SUBROGATION

A. Primary Contractor Liability (85A O.S. § 36):

1. If a subcontractor fails to secure compensation required by this act, the primary contractor shall be liable for compensation to the employees of the subcontractor unless there is an intermediate subcontractor who has workers' compensation coverage. In this event the primary contractor would have a cause of action against the subcontractor to recover compensation paid.

B. Third Party Liability (85A O.S. § 43):

1. The making of a claim for compensation against an employer or carrier for injury or death by an employee, shall not affect the right of the employee to have a cause of action against a third party.
2. The employer or employer's carrier shall be entitled to reasonable notice and opportunity to join the third part action.
3. If the employer or carrier join the third party action for injury or death, they shall be entitled to a first lien of 2/3 of the net proceeds recovered in the action that remain after payment of reasonable cost of collection.
4. An employer or carrier, liable for compensation under this act shall have the right to maintain an Action in Tort against any third party responsible for injury or death; however, the employer or carrier shall notify the claimant in writing that the claimant has right to hire a private attorney and pursue benefits.

XIII. PROCEDURE

A. Workers' Compensation Commission Proceedings (85A O.S. § 72):
   1. In making investigation or inquiry or conducting a hearing, the Administrative Law Judge and Commission shall not be bound by technical or statutory rules of evidence of by technical or formal rules of procedure except provided by this act.
   2. Hearings to be Public – Records.
      a. Hearings before the Commission shall be open to the public and shall be stenographically reported. The Commission is authorized to contract for the reporting of the hearings.
      b. The Commission shall, by rule, provide for the preparation of a record of all hearings and other proceedings before it.
      c. The Commission shall not be required to stenographically report or prepare a record of joint petition hearings. (Editor's note: The joint petition record has always been used to protect the employer as to the terms of the joint petition. It would be my recommendation to continue making a record for joint petitions so all parties are clear about the terms of the settlement and the rights the claimant is waiving.)
      d. All oral and documentary evidence shall be presented to the ALJ during the initial hearing on a controverted claim. Medical reports shall be furnished to opposing party at least 7 days prior to the hearing. Witness shall be exchanged 7 days prior to hearing.
      e. Expert testimony should not be allowed unless it satisfies the requirements of Federal Rules of Evidence 702.

B. Workers' Compensation Commission Powers (85A O.S. § 73):
   1. The Commission shall have the power to preserve and enforce order during, or proceeding before it, issue subpoenas, administer oaths and compel attendance and testimony as well as production of documents. Any person or party failing to take the oath, attend, produce documents or comply with final judgment of Administrative Law Judge or Commission or willfully refuses to pay uncontroverted medical or related expenses within 45 days can be held in contempt and fined up to $10,000.00.

C. Appeals (85A O.S. § 78):
   1. Any party feeling aggrieved by a judgment decision or award made by Administrative Law Judge may within 10 days of issuance appeal to the Workers' Compensation Commission. The Commission may reverse, modify or affirm the decision that was against the clear weight of evidence or contrary to law.
   2. The judgment decision or award of the Commission shall be final and conclusive on all questions within its jurisdiction between the parties unless an action is commenced with the Supreme Court within 20 days of the award or decision.

D. Certification to District Court (85A O.S. § 79):

1. If an employee fails to comply with final compensation judgment or award, any beneficiary may file a certified copy of the judgment or award in the office of the district court of any county in this state where any property of the employer may be found.

E. Workers' Compensation Commission – Limited Review of Compensation Judgment (85A O.S. § 80):

1. Except in the case of joint petition settlement, the Commission may review a compensation judgment, award or decision any time within six months of termination of the compensation fixed in the original compensation judgment or award on the Commission's own motion or application of either party, on the ground of a change of physical condition or on proof of erroneous wage rate. On review, the Commission may make judgment or award terminating, continuing, decreasing or increasing the compensation previously awarded subject to the maximum limits provided for this in Act.

XIV. DEFENSES

A. "Course and scope of employment" (85A O.S. §2(13)): Injury must derive from an activity of any kind or character for which the employee was hired and that relates to and derives from the work, business, trade or profession of an employer, and is performed by an employee in the furtherance of the affairs or business of an employer. The term includes activities conducted on the premises of an employer or at other locations designated by an employer and travel by an employee in furtherance of the affairs of an employer that is specifically directed by the employer. This term does not include:

1. An employee's transportation to and from his or her place of employment,
2. Travel by an employee in furtherance of the affairs of an employer if the travel is also in furtherance of personal or private affairs of the employee,
3. Any injury occurring in a parking lot or other common area adjacent to an employer's place of business before the employee clocks in or otherwise begins work for the employer or after the employee clocks out or otherwise stops work for the employer unless the employer owns or maintains exclusive control over the area or
4. Any injury occurring while an employee is on a work break, unless the injury occurs while the employee is on a work break inside the employer's facility or in an area owned by or exclusively controlled by the employer and the work break is authorized by the employer's supervisor.

B. Injury to any active participant in assaults or combats which, although they may occur in the workplace, are the result of non-employment-related hostility or animus of one, both, or all of the combatants and which assault or combat amounts to a deviation from customary duties; provided, however, injuries caused by horseplay shall not be considered to be compensable injuries, except for innocent victims (85A O.S. §2(9)(b)(1)),

C. Injury incurred while engaging in or performing or as the result of engaging in or performing any recreational or social activities for the employee's personal pleasure (85A O.S. §2(9)(b)(2)),

D. Injury which was inflicted on the employee at a time when employment services were not being performed or before the employee was hired or after the employment relationship was terminated(85A O.S. §2(9)(b)(3)),

E. Intoxication - Injury where the accident was caused by the use of alcohol, illegal drugs, or prescription drugs used in contravention of physician's orders (85A O.S. §2(9)(b)(4)). If a biological specimen is collected within twenty-four (24) hours of the employee being injured or reporting an injury, or if at any time after the injury a biological specimen is collected by the Oklahoma Office of the Chief Medical Examiner if the injured employee does not survive for at least twenty-four (24) hours after the injury and the employee tests positive for intoxication, an illegal controlled substance, or a legal controlled substance used in contravention to a treating physician's orders, or refuses to undergo the drug and alcohol testing, there shall be a rebuttable presumption that the injury was caused by the use of alcohol, illegal drugs, or prescription drugs used in contravention of physician's orders. This presumption may only be overcome if the employee proves by clear and convincing evidence that his or her state of intoxication had no causal relationship to the injury

F. Major Cause - Any strain, degeneration, damage or harm to, or disease or condition of, the eye or musculoskeletal structure or other body part resulting from the natural results of aging, osteoarthritis, arthritis, or degenerative process including, but not limited to, degenerative joint disease, degenerative disc disease, degenerative spondylosis/spondylolisthesis and spinal stenosis (85A O.S. §2(9)(b)(5)),

> "Major cause" means more than fifty percent (50%) of the resulting injury, disease or illness. A finding of major cause shall be established by a preponderance of the evidence. A finding that the workplace was not a major cause of the injury, disease or illness shall not adversely affect the exclusive remedy provisions of this act and shall not create a separate cause of action outside this act

G. Preexisting condition - except when the treating physician clearly confirms an identifiable and significant aggravation incurred in the course and scope of employment (85A O.S. §2(9)(b)(6)).

H. Mental Injury or Illness (85A O.S. § 13):

1. A mental injury or illness is not a compensable injury unless caused by a physical injury to the employee, and shall not be considered an injury arising out of and in the course and scope of employment or compensable unless demonstrated by a preponderance of the evidence
   a. Physical injury limitation shall not apply to any victim of a crime of violence.
2. No mental injury or illness under this section shall be compensable unless it is also diagnosed by a licensed psychiatrist or psychologist and unless the

diagnosis of the condition meets the criteria established in the most current issue of the Diagnostic and Statistical Manual of Mental Disorders.

3. Where a claim is for mental injury or illness, the employee shall be limited to twenty-six (26) weeks of disability benefits unless it is shown by clear and convincing evidence that benefits should continue for a set period of time, not to exceed a total of fifty-two (52) weeks.
4. In cases where death results directly from the mental injury or illness within a period of one (1) year, compensation shall be paid the dependents as provided in other death cases under this act.
    a. Death directly or indirectly related to the mental injury or illness occurring one (1) year or more from the incident resulting in the mental injury or illness shall not be a compensable injury.

I. Heart claims (85A O.S. § 14):

1. A cardiovascular, coronary, pulmonary, respiratory, or cerebrovascular accident or myocardial infarction causing injury, illness, or death is a compensable injury only if, in relation to other factors contributing to the physical harm, the course and scope of employment was the major cause.
2. An injury or disease included in subsection A of this section shall not be deemed to be a compensable injury unless it is shown that the exertion of the work necessary to precipitate the disability or death was extraordinary and unusual in comparison to the employee's usual work in the course of the employee's regular employment, or that some unusual and unpredicted incident occurred which is found to have been the major cause of the physical harm.

J. Notice - (85A O.S. § 67-68)

1. Single event Notice – Unless an employee gives oral or written notice to the employer within 30 days of the date of injury occurs, there will be a rebuttable presumption that the injury is not work related.

2. Cumulative/Occupational Notice – written notice must be given to the employer of occupational disease or cumulative trauma by the employee within 6 months after the first distinct manifestation of the disease or cumulative trauma. Unless an employee gives oral or written notice to the employer within thirty (30) days of the employee's separation from employment, there shall be a rebuttable presumption that an occupational disease or cumulative trauma injury did not arise out of and in the course of employment. Such presumption must be overcome by a preponderance of the evidence.

K. Statute of Limitations – (85A O.S. § 69):

1. Other than occupational disease, a claim for benefits under this Act shall be barred unless it is filed with the Commission within one year from the date of

injury or within 6 months from the date of the last issuance of benefits. A claim for occupational disease or occupational infection shall be barred unless it is filed within two years from the date of last injurious exposure.

2. A claim for compensation for disability on account of silicosis or asbestosis shall be filed with the Commission one year after the time of disablement and the disablement shall occur within three years from the last date of injurious exposure.
3. A claim for compensation for death benefits shall be barred unless it is filed within two years from the date of death.
4. If a claim for benefits has been timely filed under section and the employee does not: A) make a good-faith request for a hearing to resolve a dispute regarding the right to receive benefits, including medical treatment, under this title within six (6) months of the date the claim is filed, or B) receive or seek benefits, including medical treatment, under this title for a period of six (6) months, then on motion by the employer, the claim shall be dismissed with prejudice.
5. Replacement of medical supplies or prosthetics shall not toll the statute of limitations.
6. Failure to file a claim within the period prescribed in subsection A of this section shall not be a bar to the right to benefits hereunder unless objection to the failure is made at the first hearing on the claim in which all parties in interest have been given a reasonable notice and opportunity to be heard by the Commission.
7. Any claimant may, upon the payment of the Workers' Compensation Commission's filing fee, dismiss any claim brought by the claimant at any time before final submission of the case to the Commission for decision. Such dismissal shall be without prejudice unless the words "with prejudice" are included in the order. If any claim that is filed within the statutory time permitted by Section 18 of this act is dismissed without prejudice, a new claim may be filed within one (1) year after the entry of the order dismissing the first claim even if the statutory time for filing has expired.

RECENTLY ASKED QUESTIONS IN OKLAHOMA
FROM ISSUES ADDRESSED IN RECENT OKLAHOMA CASES

Q: May a claimant's permanent partial disability award be reduced because wages were paid in excess of the statutory temporary disability maximum?

A. Yes. In *Martin v. City of Tulsa*, the Oklahoma Court of Civil Appeals found that reduction of Claimant's benefits was statutorily required, and that this reduction did not conflict with municipal code requiring payment of a firefighter's salary during period of disability.

In *Martin*, the Claimant sustained a work-related injury to his right wrist. Pursuant to both 11 O.S. Supp. 2012 § 49-111 and his collective bargaining agreement, Claimant was paid his full wages during his time away from work. The wages received while recovering exceeded the statutory maximum for a temporary total disability award by a total of $13,526.19. Pursuant to 85A O.S. Supp. 2014 § 89, the city requested a reduction of Claimant's PPD award for this amount. The ALJ granted the request, and the Commission affirmed the award, rejecting all Claimant's arguments that the reduction should not apply to him, and Claimant appealed.

Section 89 requires the reduction of a PPD award by the amount of any wages paid in excess of the statutory temporary disability maximum. Claimant argued the ALJ, and thus the Commission, erred in applying § 89 to reduce his PPD award.

Claimant first argued that § 89 did not apply to him because that section only applies in cases where an employer has made "advance payments for compensation," which the Court agreed was not applicable. The payments to claimant were simply payments of his full salary, which the city was statutorily and contractually obligated to pay.

Next, Claimant argued that his collective bargaining agreement with the city precluded the application of § 89. The Court rejected this argument finding it clear that the Claimant's complaint is that the agreement simply requires firefighters to receive their full salary during periods of disability. Additionally, it was clear that Claimant received the salary and the application of § 89 to reduce his total workers' compensation benefit does not alter that fact. Nothing in the collective bargaining agreement precluded the application of §89.

Martin v. City of Tulsa, Court of Civil Appeals, Division 3, 2021 OK CIV APP 19; *see also Burson v. City of Tulsa*, Court of Civil Appeals, Division 1, 2021 OK CIV APP 8 (holding that Respondent was entitled to reimbursement of wages paid to Claimant during the temporary disability period in the amount that was excess of statutory limit).

Q: Are injuries that occur during the employee's transportation to or from their place of employment compensable when the employee had been paid mileage to relocate for the employer but was not directly reimbursed for daily travel?

A. No. In *Brown v. Infrastructure & Energy Alts., LLC*, the Oklahoma Court of Civil Appeals held that Claimant's injury did not occur within course and scope of employment when Claimant was involved in a motor vehicle accident during daily commute to a job site.

In *Brown*, Claimant and three other co-workers were carpooling to a job site on July 17, 2017, when they were involved in a collision. Claimant was a passenger in the car owned and driven by a co-worker. Respondent did not provide lodging or transportation but expected its workers to be onsite by 7:00 a.m. daily for a mandatory safety meeting.

Claimant had temporarily relocated from Texas to work on a specific project for Respondent. He had been paid mileage to relocate but was not otherwise directly reimbursed for his daily travel from his temporary residence to the job site, except for $100 per day as *per diem*.

The case's largest contention was related to Claimant's status at the time of the accident in question. Claimant argued the accident as having occurred during employer-directed travel. While Respondent argued the accident as having occurred during the employee's commute to work, which is not included in the Act's definition.

The legislature's intent was clearly to exclude commutes from the definition of scope and course of employment even though such commutes could be considered employer-directed travel generally, and certainly might be in particular situations. Further, the only direction given to the petitioner here was to get to the job site by 7 a.m. The employer was completely indifferent to how that happened and gave no direction to the petitioner as to how to get there.

Finally, the Court addressed the issue surrounding the *per diem* paid to Claimant, finding that it was simply an additional payment to the employee intended to cover the cost of working far from home. Such a payment does not convert a commute to work into employer-directed travel or make the employee incapable of commuting to work from his temporary residence.

The employer gave no direction to the employee other than where to be and when. The employee was not on any special errand but was on the way to the job site where he was to clock in and begin work each day. The employee was solely responsible to choose the method and means of his own transportation. Under these facts, the Court held that the accident occurred during the employee's transportation to and from his or her place of employment and therefore not compensable.

Brown v. Infrastructure & Energy Alts., LLC, Court of Civil Appeals, Division 3, 2021 OK CIV APP 10.

Q: Is an ALJ's order denying compensability valid when it is based on medical opinions that are not stated within a reasonable degree of medical certainty but instead based on Claimant's self-diagnosis with no other reasoning?

A. No. In *Stripling v. Department of Public Safety*, the Oklahoma Court of Civil Appeals vacated the Commission's order affirming the ALJ's decision to deny compensability, finding it was affected by errors of law and not supported by substantial evidence because the ALJ did not consider the medical report submitted to the court finding evidence of cumulative trauma.

In *Stripling*, Claimant was a state trooper with the Oklahoma Highway Patrol that filed his action in May 2017, asserting cumulative trauma injuries to his low back and left hip as a result of his employment. Claimant requested temporary total disability as well as permanent partial disability to the low back.

Claimant presented to his family doctor to receive steroid pills, steroid injections, an X-ray, as well as an MRI of his hip that revealed "significant disc protrusions in the lumbar spine, after which Claimant testified his condition did not improve. Claimant later underwent surgery to repair the herniated discs, began physical therapy, and returned to his duties as a state trooper.

Counsel for Respondent relied on a medical report that opined the disc herniation was not a result of his work as a state trooper after Claimant reported to him that the onset of his pain was after "jogging." They also focused on Claimant's own opinion and belief that the pain he was experiencing was not work related, combined with the fact that he sought medical treatment with his own private insurance carrier.

However, Claimant provided a medical report that stated that Claimant sustained a significant injury to his lumbar spine due to his work-related duties. The report also opined "the sole and major cause of the significant and identifiable injury and need for treatment to his lumbar spine is directly related to the repetitive work-related duties that he was involved in while employed by [DPS]."

On appeal, the Court emphasized that Claimant's testimony was clear and uncontroverted that until December of 2016, he was under the impression that he was suffering from a leg or hamstring injury, despite suffering from a different injury altogether in his lumbar spine. Thus, the Court agreed that Claimant's non-expert self-diagnosis should not have been relied upon as a basis for denying his claim.

Additionally, the Court held that the ALJ did not apply a "major cause" test, but instead applied a "sole cause" test to Claimant's claim. The only medical report in the record to opine on major cause is that of Claimant's. The medical reports asserting the sole cause of Claimant's spinal degeneration as jogging rely exclusively on Claimant's above-discussed self-diagnosis and offer no further reasoning. Thus, they are not stated within a reasonable degree of medical certainty and do not constitute substantial evidence.

Stripling v. Dep't Public Safety, Court of Civil Appeals, Division 2, 2021 OK CIV APP 11.

Q: Is a Claimant entitled to permanent temporary disability (PTD) benefits from the Multiple Injury Trust Fund (MITF) despite previously receiving PTD benefits for the full statutory allotted time on a claim that involved other previous injuries?

A. Yes. In *Butler v. Multiple Injury Trust Fund*, the Oklahoma Court of Civil Appeals reversed the Commission's interpretation and construction of 85A O.S. Supp. 2014 § 32(B) as barring Claimant from a PTD award against MITF, finding it was affected by error of law, reinstating Claimant's award of PTD benefits.

In *Butler*, Claimant received PTD benefits from MITF's predecessor, the Special Indemnity Fund (SIF), for a combination of adjudicated work-related injuries to Claimant's legs from July 24, 1991, to August 22, 2007. Benefits were discontinued because Claimant, born in 1942, reached age 65 in August 2007.

Claimant had previously returned to work, and in May 2010 sustained an injury to her left shoulder and left hand, for which she received a permanent partial disability (PPD) award. In May 2014, she sustained work-related injuries to her right knee, right shoulder, right hip, right arm, and right hand. She settled her claim for those injuries in November 2016 and received PPD as part of that agreement.

Claimant filed a claim against MITF, seeking PTD benefits due to the combination of her injuries. MITF admitted Claimant was PTD due to a combination of injuries but denied liability for PTD. MITF asserted that because the SIF had paid PTD benefits for more than 16 years, until Claimant reached age 65, MITF's statutory obligation had been fulfilled, and that a "second award" of PTD to Claimant against MITF was beyond the court's jurisdiction. An ALJ heard Claimant's case and rejected MITF's argument, awarding Claimant PTD pursuant to § 32 of the Administrative Workers' Compensation Act (AWCA).

MITF appealed to the WCC. While stating they agreed with the ALJ that an individual may be PTD "more than once if more than one injury is involved," the Commissioners reversed the ALJ's award.

The Court found that the Commission's interpretation of 85A O.S. Supp. 2014 § 32(B) finds legislative intent in a presumption for which we fail to find support in the law, or the evidence presented in this case. Additionally, the Court found nothing in the language of the statutes governing MITF awards suggesting the legislature intended § 32(B) to impose a "once in a lifetime" restriction barring a "physically impaired person" who timely files a claim — regardless of the claimant's age or prior awards — from receiving PTD benefits.

Butler v. Multiple Injury Trust Fund, Court of Civil Appeals, Division 2, 2020 OK CIV APP 10.

Q: May an employee prevail in a wrongful discharge action when they are terminated from an at-will position for violating the employer's social media policy?

A. No. In *Peuplie v. Oakwood Retirement Village*, Plaintiff sought review of the district court's April 19, 2018, order granting Defendant, Oakwood Retirement Village's motion for summary judgment, upon Plaintiff's wrongful termination claim, alleging her employer fired her in violation of a clearly established public policy.

Plaintiff began working for the Defendant nursing home as a CNA on March 5, 2016, and her employment was terminated on February 2, 2017, for what Defendant said was a violation of its social media policy. On January 23, 2017, Plaintiff posted two entries on her Facebook account, making negative comments about her employer and fellow employees, although Defendant, nor any fellow employees were mentioned by name within the text of the posts.

The district court found Defendant was permitted to implement and enforce a social media policy and Plaintiff violated that policy, her comments having failed to rise to the level of whistleblower complaints or public policy goals. The complaints lacked any specifics about the nature of the conduct she was criticizing, whether the conduct violated a statutory or otherwise articulated duty of care, or whether conduct she observed rose to the level of a crime or neglect against the elderly people in Defendant's care.

Plaintiff also argued that Defendant's stated reason for her termination, violation of the nursing home's social media policy, was a pretext and she was fired for reporting patient abuse. However, the record did not support Plaintiff's pretext argument. The Court found that Plaintiff's attempts to offer record facts in support of her pretext claims were not sufficient to elevate her argument beyond mere conjecture that a pretext existed. Further, the Court held that Defendant's social media reasoning for her termination from employment was not implausible or inconsistent with the record. Meanwhile, Plaintiff was wholly unable to demonstrate she was terminated from her at-will employment for any reason other than the Facebook posts at issue.

Peuplie v. Oakwood Retirement Village, Court of Civil Appeals, Division 1, 2020 OK CIV APP 40.

Q: Is an ALJ's order denying compensability proper when the Judge did not consider whether Claimant's injury was compensable pursuant to 85A O.S. § 2(9)(b)(6) and there is a report from the treating physician finding claimant sustained a significant and identifiable aggravation of a preexisting injury?

A. No. In *Fitzwilson v. AT&T Corp*, Claimant filed a CC-Form 3 on December 8, 2016, for injuries to her back and right leg, which she alleged occurred on November 22, 2016, while she "was rolling forward in chair when it toppled over." Claimant's employer denied Claimant suffered an injury arising out of and in the course of her employment.

At trial, Claimant described the accident: “We have roller chairs, and we sit in groups so that we can ask each other questions during phone calls. I had rolled back to ask a question, when I went to roll forward, my chair fell over, and I fell out of my chair.” Claimant said she believes her right hip and buttocks struck the ground.

Claimant testified she had four surgeries prior to this event. She had an L4-5 and L5-S1 fusion, she had hardware removed, she had another surgery in the same area, and she had hardware removed again. None of her surgeries involved the L3-4 disk. She had been seeing a pain management physician every three months. She began experiencing new symptoms after this fall—her pain levels were higher, and she had pain radiating down her right leg. According to Claimant, her prior issues were in her left leg.

The ALJ found that, in light of Claimant's medical records, her testimony was less than credible. The ALJ further found “that Dr. [Hendricks'] opinion is based on inaccurate history as her right leg radiculopathy was clearly present prior to November 22, 2016.” The ALJ determined, “age-related degenerative conditions, including stenosis, are specifically excepted from the definition of compensable injury pursuant to Title 85A O.S. § 2(9)(b)(5)” and was not persuaded that [Claimant's] employment was the sole or major cause of her resulting lumbar spine deterioration or degeneration that ultimately necessitated surgery.

On appeal, the Court reviewed recent case law that was found to be persuasive and applicable to the facts of the present case, holding, that even if Claimant's work-related incident, which Employer admitted occurred, was not “the sole or major cause of her resulting lumbar spine deterioration or degeneration that ultimately necessitated surgery” and is excluded from being compensable pursuant to § 2(9)(b)(5), the WCC was required to determine if her injury was compensable pursuant to § 2(9)(b)(6) because Claimant's treating physician, Dr. Hendricks, “found that Claimant sustained a significant and identifiable aggravation of her preexisting injury.”

Fitzwilson v. AT&T Corp, Court of Civil Appeals, Division 4, 2019 OK CIV APP 48.

Q: May the Workers’ Compensation Commission depart from its duty to determine if evidence supports an ALJ's order, and instead take it upon itself to comment on, reject, and weigh the evidence?

A. No. In *Rose v. Berry Plastics Corp.*, The Court of Civil Appeals reversed the WCC’s order, reinstating the ALJ’s order awarding claimant benefits. In reversing the ALJ’s order, the Court emphasized that the role of the WCC in reviewing administrative decisions is only to determine if the evidence is supportive of the order and possesses sufficient substance as to induce a conviction as to the material facts.

Claimant's CC Form 3 was filed April 11, 2017, and alleged that Claimant's left hand and wrist were crushed in a “guillotine” machine while working as a machine operator for Respondent on April 5, 2017. Employer initially provided medical treatment, but denied the claim was compensable because Claimant tested positive for marijuana and therefore Employer raised the affirmative defense of intoxication.

The ALJ found that Claimant admitted to smoking marijuana at 11:00 p.m. the night before the accident, but denied its use was a factor in the accident. His admission was later confirmed by the results of a post-accident drug test which showed Claimant "positive THC & Morphine."

On appeal, the Court emphasized that when Claimant's post-accident blood test revealed the presence of marijuana in his system, the presumption was created that the intoxication caused the injury. Further, the Court noted that it became incumbent upon Claimant to overcome this presumption by clear and convincing evidence. Regarding the WCC's actions, the Court stated that upon being presented with the ALJ's conclusion, the WCC's role was to "reverse or modify the decision only if it determines that the decision was against the clear weight of the evidence."

The Court stated that the WCC, acting in its appellate capacity, was not entitled to substitute judgment for that of the agency as to the weight of the evidence on fact questions. Several statements made the WCC demonstrated its lapse into that of a finder of fact, rather than confining its review to determine if the evidence supported the ALJ's conclusions. The WCC's error was compounded when the WCC went on to comment about the quality of Claimant's testimony as uncorroborated.

The Court of Civil Appeals held that it must reject the WCC's underlying inference that the mere presence of marijuana in Claimant's bloodstream inevitably means he was intoxicated. The Court concluded that the ALJ found that Claimant overcame the presumption by clear and convincing evidence, the WCC departed from its duty to determine if the evidence supported the ALJ's order, instead taking it upon itself to comment on, reject, and weigh the evidence, and thus affected by error.

Rose v. Berry Plastics Corp., Court of Civil Appeals, Division 4, 2019 OK CIV App 55.

Q: Is a slip and fall injury compensable when it occurs in the parking lot of a smoke-free school campus while the employee was walking back from an off-campus cigarette break on an adjacent city street?

A. Yes. In *Johnson v. Midwest Del City Public Schools*, the employer did not allow the use of tobacco on its property. Claimant went off property for an authorized smoke break and was injured in the school parking lot while returning to her workstation. The employer denied the claim on the grounds that claimant was on a work break and was not in the course and scope of employment because the injury did not occur inside the employer's facility.

It was undisputed that (1) no injury occurred to Claimant while she was outside of the employer's facility premises, (2) Claimant was "clocked in" when she fell in the parking lot, and (3) her supervisor authorized her work break. It was further undisputed that the location where Claimant smoked her cigarette complied with the employer's policy.

Employer acknowledged that Claimant was injured in the school parking lot but argued to the Commission that the injuries fell outside the definition of "course and scope of employment." The ALJ determined that because Claimant was on an authorized work

break at the time she fell inside the employer's facility (parking lot), her injuries arose in the course and scope of her employment.

The Commission reversed the decision of the ALJ, concluding that Claimant was not in the course and scope of employment because she was in the parking lot at the time of injury following her authorized work break. On appeal, Claimant focused on whether the Commission's findings were against the clear weight of the evidence, contrary to Oklahoma law or not supported by testimony presented at trial. After an analysis of the conclusions of the Commission, the Court of Civil Appeals found that the Commission's order was not affected by error of law or clearly erroneous in view of the evidence and sustained the decision of the ALJ.

The Supreme Court of Oklahoma found that the Commission's authority to modify or reverse the decision of the ALJ was limited to either finding that the decision was not supported by the clear weight of the evidence or contrary to law. The Court held that the evidence met the clear weight of the evidence standard and supported the findings and conclusions of the ALJ. Accordingly, the Commission acted in excess of its authority and contrary to law in reversing the order finding compensability and awarding TTD benefits.

Johnson v. Midwest Del City Public Schools, 2021 OK 29.

Q: Must the employer pay for reasonably necessary medical treatment if a Claimant's injury is found to be compensable?

A. Yes. In *Cameron International Corp. v. Selene Castro*, the Oklahoma Court of Civil Appeals reversed the ALJ's order denying medical treatment, finding that the employer must provide reasonably necessary medical treatment connected to the injury.

In Cameron, the claimant suffered an admitted injury to her back and was symptomatic from a disc protrusion. The Form A doctor recommended surgery. The ALJ denied Claimant's request for authorization of further treatment, which included a recommended microdiscectomy, because the ALJ believed the recommended surgery was not reasonably necessary in connection to the lumbar contusion Claimant received.

After a subsequent hearing, the Workers' Compensation Commission reversed the ALJ and found the denial of Claimant's request for surgery authorization was against the clear weight of the evidence and, accordingly, remanded the ALJ's decision for entry of an order authorizing further treatment, including surgery.

Judge Thomas Prince, the newest Court of Civil Appeals judge, wrote a unanimous opinion, and said:

> "The claimant was asymptomatic before the November 12, 2018, accident...We therefore find, like the Commission *en Banc* before us, that the recommended [surgery] is reasonably necessary in connection with the injury..."

Cameron Int'l Corp. v. Selene Castro, Supreme Court Case No. 119,305

Q: Does major cause apply to the need for medical treatment even if the Independent Medical Examiner says the major cause of the need for a total knee replacement is pre-existing arthritis?

A. No. In *Bryan Linn Farms v. Monsebais*, the employer, Bryan Linn Farms, appealed an Oklahoma WCC order reversing the decision of the ALJ, authorizing a total knee replacement surgery for Claimant's left knee.

In *Bryan Linn Farms*, the WCC held that the statutory term, "major cause," is the test for a compensable injury, but that it does not apply to medical treatment.

The claimant had pre-existing, non-symptomatic arthritis. He had an admitted injury to his knee. The treating doctor and the IME said the injury aggravated the pre-existing condition. Both agreed that a total knee replacement was reasonable and necessary. However, the treating doctor and the IME said the major cause of the need for a total knee replacement was the pre-existing condition and not the injury.

Because the Court of Civil Appeals will not reweigh evidence, they instead reviewed the record to determine if there was substantial evidence to support the Commission's decision. The Commission's decision that there was a connection between the on-the-job accident and the need for a total left knee replacement was supported by substantial competent evidence and was not contrary to law.

In the unanimous opinion of the COCA panel, Judge Keith Rapp wrote:

> "The 'major cause' analysis is not involved in determining the need for or against a particular course of medical treatment for a compensable injury. Major cause is used in the analysis of determining a compensable on-the-job injury...The employment must be the major cause of the injury, but employment does not need to be the major cause of the need for a particular course of treatment for a compensable injury. Claimant is not required to prove that the employment is the major cause of the need for a total knee replacement."

Bryan Linn Farms v. Monsebais, Supreme Court Case No. 119,058.

Q. Is the payment of costs for an independent medical examiner considered "compensation" for purposes of tolling the statute of limitations?

A. Yes. In *Brittany Smith v. Whataburger Restaurant, LLC*, Supreme Court Case No. 117,832, the Oklahoma Court of Civil Appeals found that a respondent's payment of the costs of an independent medical examiner is compensation and therefore extends the statute of limitations.

In *Smith*, the Claimant filed a CC-Form-3 on April 13, 2017, for an injury that occurred on March 9, 2017, to her low back and right hip when she slipped and fell on an ice water accumulation on the floor at her job at Whataburger. The employer denied liability and refused to pay TTD and claimant's medical expenses. In October of 2017 the employer requested the appointment of an independent medical examiner (IME)

"to address causation." The ALJ appointed Dr. Benjamin White as the IME, who examined the claimant in January of 2018, and ordered MRI's of the claimant's cervical, thoracic, and lumbar spine.

Dr. White issued a report dated February 21, 2018 recommending the claimant undergo a "Chiari decompression," a surgical procedure with an estimated recovery time of 4 to 6 months. The Respondent paid the expenses of the IME and diagnostic testing as required by 85A O.S. Supp. 2014 § 112(G). However, the Respondent continued to deny liability and refused to approve any other medical expenses or treatment. On June 18, 2018, within a week of the IME deposition but more than a year after her March 9, 2017 date of injury, Claimant filed an amended CC-Form-3, adding as injured body parts, her cervical spine, thoracic spine and her spinal cord. The employer denied the claim and raised the affirmative defense of the statute of limitations at 85A O.S. Supp. 2014 § 69(A), which bars a claim unless filed within one year from the date of injury.

The matter went to trial and the ALJ issued an order on August 7, 2018, finding a work-related injury to Claimant's low back, but holding that the one-year limitations period barred the claim of injury to her cervical spine, thoracic spine and spinal cord. The ALJ rejected the Claimant's contention that Employer's payment for services and testing provided by the IME constituted payment of "compensation" under § 69(B)(1), meaning that § 69(A) applied and barred the amended claim. The Claimant appealed to the Commission en banc, which affirmed the ALJ's decision. The Claimant then sought review by the Court of Civil Appeals.

The Court of Civil Appeals reversed and remanded the decision of the Commission. In doing so, they found the definition of "compensation" under the AWCA includes medical services and supplies. So even though an IME may not provide medical "treatment" per se, an IME's services are no less "medical services" than those of any other services provided by a medical professional. As such, an IME evaluation and testing services clearly come within the definition of "compensation" under the AWCA, and thus within the parameters of § 69(B)(1) requiring that "compensation" has been paid due to an injury before that statutory section applies.

For this reason, the Court ruled that the services received by Claimant from the IME, at employers own request and expense, triggered the extended limitations time period of § 69(B)(1) and rendered Claimant's amended CC-Form-3 timely for purposes of seeking additional compensation.

Brittany Smith v. Whataburger Restaurant, LLC, Court of Civil Appeals, Division II, Supreme Court No. 117,832

Q. Can a Court of Existing Claims Judge defer to the Workers' Compensation Commission to determine if an injury after the effective date of the Administrative Workers' Compensation Act (February 1, 2014) is the major cause of the need for medical treatment when there is a finding of a cumulative trauma injury prior to the AWCA?

A. No. In *Deckard v. Danny's Muffler & Tire*, Supreme Court Case No. 117,246, the Oklahoma Court of Civil Appeals ruled the Workers' Compensation Commission has no jurisdiction to "review an order or award made by the Court of Existing Claims for an injury occurring prior to February 1, 2014." So in turn, the Workers' Compensation Commission has no jurisdiction to determine the question of major cause of Claimant's injury in December 2013, occurring prior to February 1, 2014, the effective date of the Administrative Workers' Compensation Act.

In *Deckard*, the claimant filed a Form 3 to assert an injury to his back and left hip occurring on November 25, 2016. Claimant testified that, on that date, he picked up a tire while performing the duties of his employment, felt a pop in his left hip, and he shortly suffered a burning pain in his back. However, the claimant also admitted that, previous to the "pop," he suffered a job-related injury to his back in December 2013 for which he received treatment but alleged that the November 25, 2016 event aggravated his previous injury. The claimant also admitted he fell from his pickup truck the previous day on November 24, 2016, in a non-job related event.

Upon consideration of the testimony and evidence, the trial court held that Claimant sustained a cumulative trauma injury to his low back, date of awareness November 1, 2013, and date of last exposure November 23, 2016. However, the trial court also found the need for TTD and medical care is due to new intervening injuries, either at work on November 25, 2016, or off the job on November 24, 2016. The Court would not decide which of those incidents was the major cause for Claimant's current troubles as it was outside of the Court's jurisdiction and was to be properly decided by the Workers Compensation Commission. Both parties appealed and the three-judge panel affirmed the trial court's decision.

In reversing the order of the Workers Compensation Court and remanding back to the Workers' Compensation Court of Existing Claims to fully adjudicate the claim, the Court of Civil Appeals reasoned his cumulative trauma injury is the date of awareness, and he became aware of the injury in 2013, so the law in effect at that time governs his claim. So, the Workers' Compensation Court of Existing Claims possesses the exclusive jurisdiction to determine this matter, and the Workers' Compensation Commission is without jurisdiction to adjudicate any part of his claim.

Deckard v. Danny's Muffler & Tire, Court of Civil Appeals, Division 1, Supreme Court Case No. 117,246

Q. Does the "identifiable and significant aggravation" standard of 85A O.S. § 2(9)(b)(6) violate the substantive due process clause of Oklahoma Constitution, Article 2, § 7?

A. No. In a companion case of *Deckard v. Danny's Muffler & Tire*, Supreme Court Case No. 117,085, filed with the Workers' Compensation Commission, the Oklahoma Court of Civil Appeals found the "identifiable and significant aggravation" standard is a reasonable standard to "insure an identifiable and definite causal nexus between a pre-existing condition and a job-related aggravation thereof."

In this claim, the claimant sought review of an order of the Workers' Compensation Commission en banc which affirmed the trial courts denial of his claim for benefits for an injury to his back and left hip after the ALJ determined claimant failed to prove "an identifiable and significant aggravation of his pre-existing condition." The Claimant argued the definition of "compensable injury" contained in 85A O.S. § 2(9)(b)(6), excluding from coverage "any preexisting condition except when the treating physician clearly confirms an identifiable and significant aggravation incurred in the course and scope of the employment," unconstitutionally denied a claimant due process under Okl. Const. 2, § 7, unconstitutionally denied a claimant an adequate remedy at law under Okl. Const. art. 2, § 6, and amounts to an unconstitutional special law in violation of Okl. Const. art. 5, § 46.

In affirming the decision of the lower court, the Court of Civil Appeals reasoned that it appears reasonably clear the legislature intended that, in cases of aggravation of a pre-existing condition, it must be shown there exists a demonstrable, and not merely tangential, relationship between the pre-existing condition and the aggravation thereof by on-the job events. The Court viewed such a legislatively mandated relationship to be reasonably related to a valid public interest to insure an identifiable and definite causal nexus between a pre-existing condition and a job-related aggravation thereof and therefore found no due process violation.

Similarly, the Court found the legislature did not violate art. 2, § 6 by enactment of § 2(9)(b)(6), as "Section 6 was intended to guarantee that the judiciary would be open and available for the resolution of disputes, but not to guarantee that any particular set of events would result in court-awarded relief." Lastly, the Court held § 2(9)(b)(6) creates no subclass of claimants for special treatment in violation of art. 5, § 46 since all claimants seeking recovery of benefits for aggravation of a pre-existing condition must demonstrate the causal nexus between the pre-existing condition and the job-related aggravation, a valid state interest.

Deckard v. Danny's Muffler & Tire, Court of Civil Appeals, Division 1, Supreme Court Case No. 117,085

Q. Can an Insurance Company intervene in a wrongful death action and assert subrogation for death benefits paid in the workers' compensation claim?

A. No. In the case of *Fanning v. Travelers Insurance Company*, Supreme Court Case No. 119,037, District Judge Barry V. Denney found that 85A O.S. Section 43 is unconstitutional as it relates to subrogation in a death case.

Travelers Ins. Company paid death benefits in a claim in which the worker was killed in a job-related head-on collision. Travelers intervened in the wrongful death action and asserted a subrogation for death benefits paid. The estate of the decedent filed a Declaratory Judgment Action, alleging that the Oklahoma Constitution prohibits workers' compensation subrogation in a death case.

District Judge Barry V. Denney, found that 85A O.S. Sec. 43 is unconstitutional as it relates to subrogation in a death case. Section 43 provides that the employer or workers' compensation carrier paying death benefits is entitled to two-thirds of the net recovery in a third party wrongful death district court action up to the amount of benefits paid, or to be paid in the future.

Judge Denney based his opinion upon Article 23, Section 7 of the Oklahoma Constitution that prohibits the Legislature from diminishing damages in a wrongful death action. Judge Denney wrote:

> Article 23, Section 7 provides that workers' compensation laws will provide for the exclusive remedy against the employer and that the legislature can only limit death claims against the state or its political subdivisions. This action does not involve a political subdivision and yet, the legislature has enacted a statute that attempts to expand the limitations on death claims--the only thing Oklahoma's Constitution forbids.

Fanning v. Travelers Insurance Company, Ottawa County District Court, CJ-2018-172, Oklahoma Supreme Court No. 119037

Q. After a workers' compensation death case is admitted and benefits paid, can an intentional tort case be filed in district court?

A. No. In the case of *Farley v. City of Claremore*, the Supreme Court explained the legal rights of recovery for survivors of a worker who dies in the course and scope of employment. The opinion eliminates any right to double recovery of both workers' compensation benefits and wrongful death benefits from the same injury.

Jason Farley, a captain in the Claremore Fire Department, died while responding to a flash flood emergency. His widow and minor child were awarded statutory workers' compensation death benefits under the Administrative Workers' Compensation Act.

The widow filed a district court action (1) alleging negligence of the City of Claremore and (2) seeking benefits for the widow and child not covered by workers' compensation, i.e. grief and loss of consortium, and (3) benefits for the parents and siblings of the decedent. Such beneficiaries have a remedy in a wrongful

death action, but not in workers' compensation, unless they were dependent upon the decedent.

The Supreme Court in a 7-1 decision affirmed the district court's dismissal of the widow's petition based upon the exclusivity of workers' compensation. The courts discussion focused on the exclusive remedy of workers' compensation and the remedy of intentional torts allowed by *Wells v. Oklahoma Roofing & Sheet Metal, LLC,* 2019 OK 45, 457 P.3d 1010.

Justice Edmondson made clear and straightforward findings regarding the interaction of a workers' compensation claim prosecuted to conclusion and a subsequent wrongful death action, even if an intentional tort can be proved. Below are some of the key findings from Justice Edmondson:

> *A tort action seeking damages for a surviving spouse, surviving child, and parents of a deceased adult child does not survive... in a wrongful death action when (a) an exclusive worker's compensation remedy for survivors is substituted for a wrongful death action, and (b) the decedent's employer possesses government tort claim sovereign immunity barring a tort action for damages at the time of decedent's death...*
>
> *Wells did not approve the concept that an injured employee possessed one cause of action with a workers' compensation remedy, three actions based upon each degree of negligence, and one action based upon an intentional tort...*
>
> *Wells determined an injured employee could bring an action in District Court against an employer based upon the employer's intentional conduct as shown by the substantial certainty standard. Wells did not authorize double or multiple recovery for the same injury.*
>
> *When the workers' compensation statutes provide an exclusive remedy for an alleged wrongful conduct, this is the remedy that must be pursued...Wells explains, a remedy for an injury caused by an intentional tort by an employer lies in a District Court, but an "accidental" harm or injury arising from negligence is provided for by the workers' compensation statutes.*
>
> *A cognizable workers' compensation death-benefits award of compensation, available at the time of a decedent's death, bars a subsequent tort action for the same injury against the employee's employer.*

Farley v. City of Claremore, 2020 OK 30

Q. If an injury occurs behind employer's retail location, but in a general parking lot, is the claim compensable?

A. No. In the case of *Yvonne Lobb v. Dyne Hospitality Group*, Division II of the Oklahoma Court of Civil Appeals affirmed the Workers Compensation Commissions denial of compensability.

In *Lobb*, the Claimant walked out to her car after her shift had ended and fell in the parking lot on ice. The Respondent denied compensable injury to the left knee as the claimant's alleged injury did not arise out of the course and scope of employment since

she had stopped work for the day and was in a parking lot not owned or maintained by the Respondent when she fell.

The Court of Civil Appeals determined that an injury that occurred behind the employer's retail location, but in a general parking lot, is not compensable. The opinion sets out a detailed defense of 85A § 2(13)(c) that excludes the compensability of injuries that occur in a parking lot or other common area adjacent to an employer's place of business before or after work.

In this case, the injury occurred in a parking lot over which the employer had no control. The employer was not responsible for maintenance, including snow or ice removal, per the lease agreement. The COCA rejected claimant's contention that the statute was arbitrary, capricious, or unfair. In 2019, the legislation made compensable any injury that occurs in a parking lot or common area if the employer has control. That fact pattern did not occur in this case.

Yvonne Lobb v. Dyne Hospitality Group, Supreme Court No. 118,843

Q. When the AWCA prohibits a parent of an adult child from receiving benefits under 85A O.S. § 47, does exclusive remedy prevent a district court action for wrongful death?

A. No. In the case of *Whipple v. Phillips and Sons Trucking, LLC*, the Oklahoma Supreme Court has ruled that the mother of an unmarried and childless son who was killed in a work-related accident is allowed to bring a wrongful death action in district court despite the exclusivity of the workers' compensation law.

A parent cannot receive benefits for the death of an adult child under the Administrative Workers' Compensation Act (AWCA). Death benefits are generally available only for a spouse, minor children, or disabled children. The appeal came from the district court of Canadian County where a judge granted summary judgment on the grounds that the mother's remedy was in workers' compensation.

Justice Kauger authored the opinion that says that the mother's remedy lies only in district court even though the AWCA says all work-related injuries are under the jurisdiction of the Oklahoma Workers' Compensation Commission.

Justice Kauger said the right of a parent as the next of kin to bring a wrongful death action when the decedent is an adult, unmarried, and childless, is "crystalized in the law" pursuant to Article 23, Section 7 of the Oklahoma Constitution. Justice Kauger wrote, "Therefore, the Legislative attempt to deny recovery for wrongful death pursuant to [the compensation death statute] to the mother of her unmarried, childless son is unconstitutional.

The employer argued that not allowing benefits to the mother in workers' compensation was not abrogating the right of the mother to recover under workers' compensation, but just limited any recoverable amount (which was zero).

Justice Kauger said, "Constitutionally, [the mother] cannot be cut off from a remedy altogether. Accordingly, our only choice it to allow her to pursue her action for the wrongful death of her son in the District Court."

In commenting on Article 23, Section 7, the opinion says, "In 1950, art. 23 section 7 transferred work-related death claims to the purview of the workers' compensation laws. However, the constitution contains a caveat that precludes the Legislature from ever abrogating the right to recover for wrongful death as it existed when 23 Section 7 was adopted."

Whipple v. Phillips and Sons Trucking, LLC, 2020 OK 75

Notes Pages

Notes Pages

Notes Pages

Notes Pages

MEDICAL MARIJUANA IN THE WORKPLACE

I. History

A. Legal but regulated until the 20th century.

B. War on Drugs caused the outcry to prohibit use of all drugs including marijuana.

C. Impairment

i. Substantial reduction in blood flow to the temporal lobe of the brain, which governs auditory attention – 29 Quinnipiac L. Rev. 1001

ii. Large individual differences attributable to the test subject and other situational factors. – 29 Quinnipiac L. Rev. 1001

D. Medical value

i. Used for nausea, glaucoma, migraines, arthritis, and appetite stimulation for those suffering from conditions like HIV, AIDS wasting syndrome or dementia, and many more medical conditions.

II. Current Status

A. Controlled Substance Act, 21 U.S.C. § 823(f) (2012)

i. Labels marijuana as a Schedule I drug, thus prohibits the cultivation, possession, transportation or use of cannabis.

ii. Also does not recognize any medicinal value

B. Preemption

i. CSA only preempts those state medical marijuana statutes that provide an affirmative right to medical marijuana – 29 Quinnipiac L. Rev. 1001

ii. Many states avoid preemption by using language that does not legalize marijuana, but does not punish certain marijuana offenses under state power – 29 Quinnipiac L. Rev. 1001

C. State laws began allowing medical marijuana despite the CSA, but federal agents could still enforce federal law

i. *Gonzales v. Raich* – state law allowing marijuana in any capacity does not prohibit federal officers enforcing federal marijuana laws

ii. Due to the Supremacy Clause and Commerce Clause

D. Although still illegal, no action can be brought if in compliance with state medical marijuana laws

i. Consolidated Appropriations Act of 2017 – 115 P.L. 31, Sec. 537; Enacted HR 244, Pg. # 154 – division B, title II: Forbids any funding being used by the DOJ for any action that prevents state law made for use, distribution, possession, or cultivation of medical marijuana.

ii. This does not apply to states with recreational marijuana.

iii. Must be in full compliance with state law in order to apply – *United States v. McIntosh*, 833 F.3d 1163 (9th Cir. 2015)

III. MVP Practice States

A. Those with medical marijuana have fairly good employer protections and exemptions.

B. The overall issue is the state laws which allow some sort of use of marijuana are in direct conflict with the Controlled Substances Act. The CSA classifies marijuana as a Class I drug which is illegal.

C. Arkansas - Medical Marijuana – tit. IV, Sub. 1, Ch. 124D
   i. Employers not prohibited from making drug-free workplaces (b)(2)
   ii. Cannot discriminate based on status as a qualifying patient (f)(3)

D. Illinois – Medical Marijuana
   i. 410 ILCS 130/50 – Employment/Employer liability
   ii. Does not prohibit employers from creating and enforcing a drug-free workplace policy unless it is used in a discriminatory manner.
   iii. Does not create a defense for a third party who fails a drug test
   iv. Does not prohibit employers from disciplining an employee who failed a drug test if failing would put the employer in violation of federal law or cause it to lose a federal contract or funding.
   v. Does afford a qualified employee a reasonable opportunity to contest the basis of a drug test determination.
   vi. Does not create a cause of action for any person against an employer for:
      1. Actions based on an employer's good faith belief that an employee used cannabis on the employer's premise.
      2. Actions based on an employer's good faith belief that an employee was impaired while working on the employer's premises during hours of employment.
      3. Injury or loss to a third party if the employer neither knew nor had reason to know that the employee was impaired.
   vii. 410 ILCS 130/40 Discrimination Prohibited
      1. No employer may penalize a person solely for his or her status as a registered qualifying patient, unless failing to do so would put the employer in violation of federal law or unless failing to do so would cause it to lose a monetary or licensing-related benefit under federal law or rules.
      2. No employer may be penalized or denied any benefit under State law for employing a cardholder.
      3. Employer does not have to pay for the medical use.
   viii. As of January 1, 2020, Illinois legalized recreational cannabis. The Illinois Cannabis Regulation and Tax Act does not prohibit employers from adopting reasonable drug free workplace policies or require employers to

permit an employee to be under the influence of or use cannabis while performing the employee's job duties. 410 ILCS 705/10-50.

E. Iowa – Medical Marijuana for Epilepsy – HB 524 passed May 12, 2017
   i. Does not address employer's responsibilities
   ii. Does not address discrimination
F. Kansas – Illegal
G. Missouri – Medical Marijuana legalized in 2018
H. Nebraska – Illegal
I. Oklahoma – Medical Marijuana for chronic conditions only in 2018

IV. Effects on the Workplace – Federal Issues

A. Federal Criminal Accomplice Liability
   i. This may occur if state law requires employers to pay for medical marijuana through the employee's insurance or workers' compensation.
   ii. May not be an issue, for the moment, since the Consolidate Appropriations Act of 2017 forbids DOJ to use funding to prosecute such matters
B. Loss of Federal Contracts
   i. 41 U.S.C.§§ 8102 (contracts), 8103 (grants)
   ii. Drug-Free Workplace Act of 1988 –
      1. Requires employer who receive federal contracts or grants valued over $100,000 "to certify to the federal agency involved that it will provide a drug free workplace".
      2. An employer's obligations include disciplinary action on any employee who does not comply 41 U.S.C. § 8104
      3. Penalties for failure to comply
         - Suspension of payments
         - Termination or suspension of the contract
         - Prohibition from future federal contracts up to five years
   iii. There are no exceptions for employers bound by state law
C. Workplace Safety Violations - Occupational Safety and Health Act of 1970 (OSH Act) – 29 U.S.C. § 654(a)(1) (2012).
   i. An employer must "furnish to each of his employee's employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees."
   ii. OSHA does not explicitly address marijuana in the workplace but covers any impermissible harm.
   iii. Penalties for noncompliance range from $5,000 to $70,000 in fines and up to a year in prison if hazard caused the employees death. – 29 U.S.C. 666

D. Discrimination through the American with Disability Act

i. Centers on the Employer's Policy

1. If there is no drug policy, there is a high chance of proving discrimination.
2. If there is a drug policy, there may still be an issue because most policies require consequences for "under the influence" at work but most drug tests are for use rather than impairment. – 49 J. Marshall L. Rev. 193

ii. Employers need not accommodate medical marijuana users as the federal government has not acknowledge marijuana as a legitimate medical treatment.

iii. Legalization of Marijuana Raises Significant Question and issues for Employers

1. If medical marijuana users are covered is dependent on whether marijuana is considered illegal under the ADA
   - ADA defines illegal use of drugs as use of drugs that are unlawful to distribute or possess under the CSA, which includes marijuana.
   - The ADA definition excludes use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the CSA or other provisions of Federal law. Every medical marijuana user must receive a prescription card from a licensed health care professional. 42 U.S.C.A. § 12111(6) (West 2011).

iv. Protection afforded

1. Regarded as if an employer mistakenly believes that an employee's use of medical marijuana substantially limits one or more major life activities, when in fact the impairment is not substantially limiting. – 29 Quinnipiac L. Rev. 1001; 42 U.S.C.A. § 12114(b)(3) (West 2011)
   - A claim could arise if an employer mistakenly believes an employee's use of medical marijuana substantially limits one or more major life activities (work), when in fact the impairment is not substantially limiting.
   - A user would need to prove the employer perceived him or her as unable to work in a broad class of jobs rather than just one job such as operating heavy machinery.
2. Disparate impact – an employer cannot use any selection criteria that results in the rejection of an individual with a disability or a class of individuals with disabilities unless the standard, test or other selection criteria is shown to be job-related for the position in question and is consistent with business necessity. - 42 U.S.C.A. § 12112(b)(6) (West 2011).
   - A successful case would need to show an employer's policy of excluding those who test positive for marijuana. This tends to screen out a greater proportion of persons with disabilities, compared to persons without disabilities. – 29 Quinnipiac L. Rev. 1001

3. Medical examinations or inquiry into disabilities - Prohibits employers from requiring medical examinations or making disability inquiries of employees unless such examinations or inquiries are job-related and consistent with business necessity. § 12112(d)(4)(A)
    - Protects all employees from the employer uncovering the employee's health defects at its own direction.
    - The type of medical examination is determined on a case-by-case basis.
        1. If an employer's non-invasive explanation and objective evidence shows its drug-testing protocol is unlikely to reveal employees' medical information, then the testing does not qualify as a medical examination. – *Bates v. Dura Auto. Sys*., Inc., 767 F.3d 566 (6th Cir. 2014)
        2. Disability inquiry is also determined on a case-by-case basis
            - It may include asking an employee whether s/he currently is taking any prescription drugs or medications, or did in the past, or monitoring an employee's taking of such drugs or medications. - *Bates v. Dura Auto. Sys., Inc.*, 767 F.3d 566 (6th Cir. 2014)
            - Able to ask about non-disability impairment and illegal-drug abuse.

v. Employer's defenses

1. Job related and business necessity – when an employer has a reasonable belief, based on objective evidence, that: - EEOC instruction – *Bates v. Dura Auto. Sys., Inc.,* 767 F.3d 566 (6th Cir. 2014)
    - An employee's ability to perform essential job functions will be impaired by a medical condition; or
    - An employee will pose a direct threat due to a medical condition
    - Significant risk to health or safety of others that cannot be eliminated by reasonable accommodation
    - Must be based on the specific position and not general assumptions

V. Effects on the Workplace – State Issues

A. State non-discrimination laws

i. Varies state to state

ii. Depends on:

1. Whether the state's disability law excludes coverage for illegal drug users like the ADA and the scope of that exclusion.
2. The enforceability of a state's medical marijuana statute.
3. Whether a private cause of action is afforded by either statute.
4. Whether accommodation is required by either statute.

B. Civil Liability for Employee Actions
    i. Respondeat superior
    ii. Negligent hiring
    iii. Negligent retention

VI. Proactive Steps for Employers to Protect Themselves

A. Testing procedures
    i. In hiring, wait until a tentative offer is made before requiring a drug test because the ADA prohibits a medical examination prior to such offer. – 29 Quinnipiac L. Rev. 1001
    ii. Narrow testing and medical inquiries as much as possible to avoid over intrusive and broad questions.
        1. Medical Review and Medical Review Officers aid in this aspect
        2. Only ask those questions that are job-related
    iii. Reasonable Suspicion Testing
        1. Do not inquire into marijuana use unless there is suspicion of use affecting the employee's work or safety issues.
        2. This could avoid some liability in the civil realm.
    iv. Use Third-party testing
        1. Have them screen out any irrelevant medications or validly prescribed medications. Have a third-party test and discuss the employee medications to assure a valid test then relay only the pertinent medications regarding safety or illegality of employment to the employer. This does not necessarily reveal information about a disability. – *Bates v. Dura Auto Sys*., 767 F.3d 566 (6th Cir. 2014)
        2. Be careful though, because employers may not use third parties to circumvent ADA protections. – *Bates v. Dura Auto Sys*., 767 F.3d 566 (6th Cir. 2014)

B. Assure a causal connection between any screening tool or selection procedures and job-relatedness, business necessity, or workplace safety.
    i. Job relatedness - predictive or significant correlation with performance of the job's essential functions.
    ii. Business necessity - substantially promotes the business needs.
    iii. Safety in the workplace – considers the magnitude of possible harm as well as the probability of occurrence.

C. Always make an individual determination based on objective findings
    i. If an employee fails a drug test for potential prescription medications, have a physician examine the employee and the employee's medical history to determine if they are capable of performing the job. – 29 Quinnipiac L. Rev. 1001

ii. An employer has an obligation to conduct an individualized review to avoid regarding someone as having a disability – 29 Quinnipiac L. Rev. 1001

D. Avoid any indication of generalized statements about or actions against disabilities.

E. Example of allowable testing: *Wice v. Gen. Motors Corp*., No. 07-10662, 2008 U.S. Dist. LEXIS 106727, at 8 (E.D. Mich. Dec. 15, 2008).

i. Had blanket policy to send all driver employees with certain medical conditions, such as high blood pressure or diabetes, to employer's physician.

ii. The physician would then make an individual determination based on the specific employee's condition and capabilities, and not disclose medical information to employer.

Notes Pages

Notes Pages

Notes Pages

TOXIC EXPOSURE IN MISSOURI WORKERS' COMPENSATION

I. History

A. Pre-2005: the exclusive remedy provisions of the workers' compensation statute applied to both accident claims and occupational disease/injury claims. Benefits in accident and occupational disease cases include PTD, TTD, PPD, Death and medical.

   i. Accident—traumatic event that happens in one work shift

   ii. Occupational disease—repeated exposure causes disease or injury to develop over time

B. After 2005: under strict construction, courts held that since the statute only specifically discussed "accident" cases falling under the exclusive remedy, occupational disease causes such as carpal tunnel syndrome and silicosis could be litigated either through workers' compensation or through the civil courts.

   i. Benefits remained the same in accident cases

   ii. In occupational disease cases the claimant could elect for workers' compensation benefits OR civil remedy

C. In 2014: a tradeoff was negotiated which provided that toxic exposure cases could be protected under exclusive remedy of the workers' compensation system, but an enhanced benefit would be provided.

   i. Enhanced Remedy Benefits include additional amounts in addition to the pre-2014 benefits.

   ii. There are two categories of enhanced remedy/toxic exposure, each with their own set of rules:
      - Mesothelioma; and
      - Non-Mesothelioma

   iii. *Under both, the employee must be permanently and totally disabled or deceased.*

D. On January 1, 2014, a new category of occupational disease was added to the coverage afforded under the Missouri Workers' Compensation law. These diseases, known as "occupational diseases due to toxic exposure" which result in permanent total disability or death, are provided pursuant to RSMo §287.200.4.

II. Occupational Diseases Due to Toxic Exposure

A. RSMo §287.020.11 provides that 11 diseases fall within this category:

   i. Mesothelioma - Cancer of the pleura. It's a deadly form of cancer generally caused by exposure to asbestos.

   ii. Asbestosis - Lung disease resulting from the inhalation of asbestos particles, marked by severe fibrosis and a high risk of mesothelioma.

iii. Berylliosis - Chronic allergy-type lung response and disease caused by exposure to beryllium.

iv. Coal Workers' Pneumoconiosis - Accumulation of coal dust in lungs

v. Bronchiolitis Obliterans - Popcorn lung, results in obstruction of the smallest airways of the lungs due to inflammation.

vi. Silicosis - Type of pneumoconiosis marked by inflammation and scarring in the form of nodular lesions in the upper lobes of lungs. Caused by inhalation of crystalline silica dust.

vii. Silicotuberculosis - Silicosis associated with tuberculous pulmonary lesions

viii. Manganism - Toxic condition resulting from chronic exposure to manganese

ix. Acute Myelogenous Leukemia - Cancer of blood and bone marrow link to exposure to certain chemicals, such as benzene.

x. Myedolodysplastic Syndrome - Group of disorders caused by poorly formed or dysfunctional blood cells associated with exposure to tobacco smoke, pesticides, industrial chemical, and heavy metals like lead and mercury.

III. §287.200.4(2) Occupational Diseases NOT Including Mesothelioma

A. For compensable claims of permanent total disability involving asbestosis, berylliosis, coal worker's pneumoconiosis, brochiolitis obliterans, silicosis, silicotuberculosis, manganism, acute myelogenous leukemia, and myelodysplastic syndrome benefits are owed at the rate of 200% of Missouri's average weekly wage at the TIME OF DIAGNOSIS for 100 weeks.

   i. Benefits are calculated at the time of diagnosis and NOT the time of last exposure to the risk.

   ii. Employer and Insurer are still liable for past medical bills and past TTD (if applicable) in addition to these benefits.

   iii. PTD Benefits under 287.200.1 must still also be provided

B. For compensable death claims involving asbestosis, berylliosis, coal worker's pneumoconiosis, brochiolitis obliterans, silicosis, silicotuberculosis, manganism, acute myelogenous leukemia, and myelodysplastic syndrome benefits are owed at the rate of 200% of Missouri's average weekly wage at the TIME OF DIAGNOSIS for 100 weeks

   i. PLUS § 287.240 Death Benefits: reasonable expenses of the burial of the deceased employee NOT exceeding $5,000, lifetime benefits for total dependents (spouse/children) calculated using the employee's average weekly wage during the year immediately preceding the injury that results in the death.

IV. RSMo § 287.200.4

For all claims filed on or after January 1, 2014, for occupational diseases due to toxic exposure which result in a permanent total disability or death, benefits in this chapter shall be provided as follows:

(1) Notwithstanding any provision of law to the contrary, such amount as due to the employee during said employee's life as provided for under this chapter for an award of permanent total disability and death, except such amount shall only be paid when benefits under subdivisions (2) and (3) of this subsection have been exhausted;

(2) For occupational diseases due to toxic exposure, but NOT INCLUDING MESOTHELIOMA, an amount equal 200% OF THE STATE'S AVERAGE WEEKLY WAGE AS OF THE DATE OF DIAGNOSIS FOR 100 WEEKS paid by the EMPLOYER; and

(3) In cases where occupational diseases due to toxic exposure are DIAGNOSED TO BE MESOTHELIOMA:

For employers that have ELECTED to ACCEPT MESOTHELIOMA LIABILITY under this subsection, an additional amount of 300% OF THE STATE'S AVERAGE WEEKLY WAGE FOR 212 WEEKS SHALL BE PAID BY THE EMPLOYER; or

For employers who REJECT MESOTHELIOMA COVERAGE under this subsection, then the EXCLUSIVE REMEDY PROVISIONS UNDER SECTION 287.120 SHALL NOT APPLY TO SUCH LIABILITY…and

(4) The provisions of subdivision (2) and paragraph (a) of subdivision (3) of this subsection shall not be subject to suspension of benefits as provided in subsection 3 of this section; and

(5) Notwithstanding any other provision of this chapter to the contrary, should the employee die before the additional benefits provided for in subdivision (2) and paragraph (a) of subdivision (3) of this subsection are paid, THE ADDITIONAL BENEFITS ARE PAYABLE TO THE EMPLOYEE'S SPOUSE OR CHILDREN, NATURAL OR ADOPTED, LEGITIMATE OR ILLEGITIMATE, IN ADDITION TO BENEFITS PROVIDED UNDER 287.240. If there is no surviving heirs……the remainder of such additional benefits shall be paid as a single payment to the estate of the employee;

(6) The provisions of subdivision (1) of this subsection shall not be construed to affect the employee's ability to obtain medical treatment at the employer's expense or any other benefits otherwise available under this chapter.

V. Qualifying for Mesothelioma Enhanced Remedy

A. Employer must elect coverage for Mesothelioma toxic exposure under the workers' compensation act.

B. If employer does not elect coverage, they could be liable for civil claims because the employer could receive no exclusive remedy protection if they fail to specifically elect coverage.

C. Election of coverage, however, does **NOT** apply to non-mesothelioma toxic exposure.

VI. Electing Coverage

A. § 287.200.4 requires that an employer ELECT coverage under the statute. This causes a variety of different issues in situations where:

   i. Multiple different employers existed

   ii. Employer has been bought out multiple times

   iii. Employer no longer exists

   iv. Multiple different insurance companies have insured the employer over the years.

   v. Multiple different insurance companies have owned employer's policy

VII. § 287.200.4(3) Mesothelioma

A. MESOTHELIOMA benefits are owed at the rate of 300% of Missouri's average weekly wage for 212 weeks IF the employer has elected to accept mesothelioma liability.

B. If the employer did not elect coverage, they are subject to civil liability and the exclusive remedy provision of the statute does not apply.

C. Note that the Employer and Insurer will still be liable for past medical bills and past TTD (if applicable) in addition to these benefits.

D. Note that the "triggering occurrence," or the event which commences liability, is the ***filing of a claim***. Liability attaches for enhanced benefits at the time the claim is filed. *See Accident Fund Insurance Co. v. Casey*, 2018 WL 2311331 (Mo. banc 2018).

E. PTD Benefits under 287.200.1 must also still be provided.

F. **PLUS 287.240 Death Benefits:** reasonable expenses of the burial of the deceased employee NOT exceeding $5,000, lifetime benefits for total dependents (spouse/children) calculated using 2/3 of the employee's average weekly wage during the year immediately preceding the injury that results in the death.

VIII. Who Can Collect Enhanced Remedy Benefits?

A. Enhanced Remedy benefits payable to:

   i. Employee's spouse.

   ii. Children (natural, adopted, legitimate, or illegitimate).

   iii. Estate of employee.

B. Traditional Benefits, on the other hand, are only payable to dependents:

i. Employee's spouse or children under the age of 18 or 22, depending on the situation

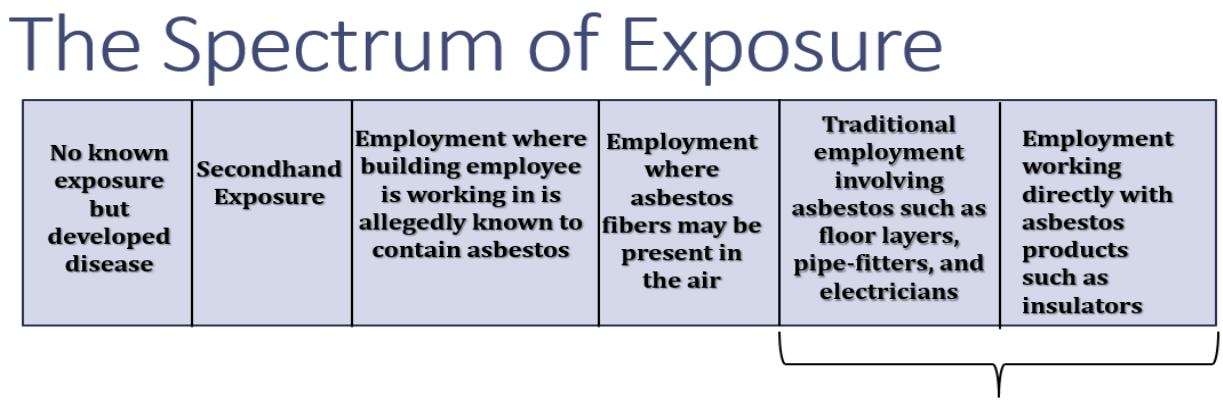
ii. If no dependents, only pay medical and/or burial expense on death case.

IX. What Qualifies as Exposure?

As with the traditional categories of occupational disease, in toxic exposure cases an employee shall be deemed to have been exposed to the hazards of an occupational disease when he is employed in an occupation or process in which the hazard of the disease exists. RSMo. §287.063; see *Casey v. E.J. Cody Co., Inc.*, 2017 WL 465992 (Mo. Ind. Rel. Com.) (*affirmed in part by Accident Fund Insurance Co. v. Casey*, 2018 WL 2311331 (Mo. banc 2018)).

Just as a claimant in a repetitive trauma case must prove his employer exposed him to the hazards of repetitive trauma, a claimant in a toxic exposure case must prove that his job duties exposed him to the toxins that allegedly caused his disease. This can be accomplished by analyzing company records, job descriptions, obtaining industrial hygienist, or deposing the claimant regarding products he worked with and jobs he worked on.

The courts have not provided clarity on what constitutes exposure and whether the analysis for determining exposure differs in cases for toxic exposure vs. occupational disease claims that do not involve toxic exposure. However, the Court of Appeals implied that an employee showing a probability that asbestos existed in the workplace was enough to prove exposure and causation.



X. Which Employer/Insurer is liable?

In amending the statute to include cases of toxic exposure, the Legislature failed to outline whether the insurer at the last exposure would be liable for benefits or whether the insurer as of the "date of first significant effects," "date of disability," "date of diagnosis," "date of death," "date of injury," or some other date would be liable for benefits.

The Missouri Supreme Court has held that the insurer providing a policy which elects coverage on the date the claim is filed could be the one liable for the enhanced

benefits under 287.200(3)(4). *See Accident Fund Insurance Co. v. Casey*, 2018 WL 2311331 (Mo. banc 2018). Therefore, the Last Exposure Rule under 287.063(2) does not apply to carrier liability in enhanced remedy cases, when deciding liability between two insurance carriers who provided insurance for the same employer at different times. In this case, the insurance carrier on the date the claim is filed is liable for enhanced remedy benefits. Prior to the Missouri Supreme Court's decision, the Commission concluded the insurer as of the "date of disability" or "date of diagnosis" would have been liable for enhanced benefits.

It has not been conclusively decided whether the insurer at last exposure would be liable for any other benefits such as burial expenses or death benefit. However, the Commission in *Landis v. St. Luke's Hospital* No. 17-098196, 2020 WL 1977939 (Mo. Lab. Ind. Rel. Com. Apr. 16, 2020) held that the insurance carrier on the date of last exposure was liable for both traditional and enhanced remedy benefits. In *Landis*, the Commission was asked to decide which of several employers—St. Luke's Hospital, Children's Mercy Hospital, or Truman Medical Center—was liable for both traditional and enhanced remedy benefits.

Ultimately, the Commission held that Children's Mercy Hospital was liable for traditional benefits under the last exposure rule. Additionally, it held that the last exposure rule dictated that Children's Mercy Hospital was also liable for enhanced remedy benefits as "the last employer to expose the employee to the hazard of the occupational disease prior to evidence of disability."

Similarly, the Commission in *Hayden v. Cut-Zaven, Ltd.*, 614 SW3d 44 (Mo Ct of Appeals, ED 2020) held that the last exposure rule does apply in deciding which employer is liable for traditional benefits. Enhanced remedy benefits were not awarded because the employer was defunct prior to 2014 and therefore could not have "elected" coverage for enhanced benefits, similar to the situation in *Hegger v. Valley Farm Dairy Co.*, 596 S.W.3d 128 (Mo. banc 2020). *Hayden* was remanded to the LIRC and is now being appealed again to the Missouri Court of Appeals.

XI. Missouri Supreme Court Decisions

Accident Fund Insurance Co. v. Casey, 550 S.W.3d 76 (Mo. banc 2018).

In *Casey*, the decedent worked for the employer from 1984 to 1990 installing and repairing floor tile. He was diagnosed with mesothelioma on November 5, 2014. The decedent filed a claim for workers' compensation benefits against his employer in February 2015 and died from the disease on October 11, 2015. The Accident Fund insured the employer's Workers' Compensation coverage from March 16, 2014 through March 16, 2016 which included the dates the decedent was first diagnosed with mesothelioma and the date of death. At hearing, the decedent was only seeking an award of enhanced mesothelioma benefits and not any additional compensation he may have been entitled to under the statute. The decedent prevailed, and the case was ultimately appealed to the Missouri Supreme Court by the insurer, Accident Fund Insurance Company. This case was the first decision issued which provided binding precedent related to 287.200.4.

On appeal to the Missouri Supreme Court, Accident Fund contended that they did not cover liability for the enhanced benefit. Accident Fund argued that the last exposure rule under Section 287.063.2 meant that the insurer in 1990 when the decedent retired, was liable for the enhanced benefit under the new law.

The Court held that the last exposure rule was immaterial in enhanced benefit claims involving a single employer, where the employer purchased a policy explicitly covering benefits under 287.200.4.

- The Court noted that the insurance policy's endorsement did not contain any qualifying language regarding the last exposure rule.
- The Court also noted the only qualifying language in the endorsement limited coverage to claims filed after January 1, 2014.

The relevant inquiry in the matter was not under whose employment the employee was last exposed, but whether the terms of the employer's policy provided coverage for 287.200.4. This is because in *Casey*, there was only a single employer. **Because the insurer expressly adopted 287.200.4 into its endorsement, it provided coverage for the enhanced remedy.**

- Essentially, the Court held that the endorsement was not an occurrence policy but rather a claims-made policy.

The Court held that since 287.200.4 made no reference to the last exposure rule, it did not apply to insurers in enhanced remedy cases involving a single employer. The Court went on to find that the insurer at the time the claim for compensation is filed is the one liable for enhanced remedy benefits.

- The Court advised that applying the last exposure rule would allow for insurers to sell "illusory, hollow" policies because essentially nobody after 2014 has been exposed to asbestos.

Hegger v. Valley Farm Dairy Co., 596 S.W.3d 128 (Mo. banc 2020).

The Missouri Supreme Court addressed in H*egger* whether an employer that did not exist when the 2014 toxic exposure changes were enacted could be held liable for enhanced mesothelioma benefits.

The employee, Vincent Hegger, worked for Valley Farm Dairy from 1968 to 1984. Valley Farm maintained a workers' compensation policy during that time; however Valley Farm did not exist when the enhanced remedy benefits were enacted on January 1, 2014. Hegger serviced industrial machinery which exposed him to asbestos gaskets, asbestos insulation, and other asbestos containing materials. Hegger was diagnosed with mesothelioma caused by exposure to asbestos in 2014 and died from the disease in 2015.

The Court first held that under the January 1, 2014 changes, an employer must elect to accept their mesothelioma liability. The Court then held that a now-defunct employer is not considered to have elected to accept mesothelioma liability solely by maintaining a workers' compensation insurance policy at the time of the employee's exposure to asbestos.

Specifically, the Court focused on the operative term “elect,” stating that the plain and ordinary meaning of the term is to make a selection or to choose. The Court then explained that Valley Farm could not have “elect[ed] to accept mesothelioma liability” under changes to the statute that did not take effect until sixteen years after the company ceased to exist.

In conclusion, the Court found that an employer ceasing to exist before the January 1, 2014 changes were enacted, could not possibly “elect” to accept mesothelioma liability. Importantly, if an employer does not elect to insure their enhanced mesothelioma liability, they do not fall within the exclusivity provision of the Missouri Workers’ Compensation Act and can be sued in civil court.

XII. Decisions Currently Pending on Appeal

Marc Hayden v. Cut Zaven Ltd., and Papillion Ltd., Injury No.: 14-103077

Hayden is the first case that required the application of not only enhanced benefits, but also traditional benefits on a toxic exposure claim of mesothelioma.

In *Hayden*, the employee contended that certain hairdryer models contained asbestos, and he was exposed to that asbestos because he used these models, which emitted the fibers. The Employee was unable to recall specific models and did not have any studies or scientific evidence to support the contention that asbestos containing hairdryers were linked to mesothelioma diagnoses in those who used them.

The presiding ALJ initially denied benefits due to the employee being unable to establish medical causation between his diagnosis of mesothelioma and his work for numerous years as a hairdresser. In finding the employee’s exposure to hair dryers was not the prevailing factor behind his mesothelioma diagnosis, the ALJ referred to the opinion of one of the Insurer’s doctors stating; “[There] was good probability Employee was never subject to the risk of asbestos exposure because only certain models and serial numbers of the hairdryers he recalled using contained asbestos. [Insurer’s doctor] testified there were no studies linking employment as a hairdresser to an increase in developing mesothelioma.”

On appeal, the Court of Appeals reversed and implied that an employee showing a probability that asbestos existed in the workplace was enough to prove exposure and causation. The Court of Appeals then remanded to the Commission to determine the applicability of the last exposure rule to the case and to determine which employer was liable for both traditional and enhanced remedy benefits.

On remand, the Commission held that Employee was not entitled to enhanced remedy benefits as Employer ceased to exist prior to the enactment of the enhanced remedy benefits statute in 2014 and therefore the outcome was controlled by *Hegger*. It also held that the last exposure rule applied to traditional benefits and that the employer who last exposed Employee to the hazard of the occupational disease prior to

evidence of disability, regardless of the length of time of such last exposure, was liable for traditional benefits.

Hayden was re-appealed to the Missouri Court of Appeals.

XIII. Enhanced Remedy Questions Which Remain Unanswered

A. Only the surface of questions involving the enhanced remedy statute has been scratched to this point. A number of questions regarding how an Administrative Law Judge or the Commission will rule in these types of cases still remain unanswered. These questions likely will be answered in the future when issues involving them are litigated. Some of these questions include:

   i. Party responsible for traditional benefits?
   ii. The date of injury?
   iii. Subrogation interests for traditional benefits?
   iv. The standard to establish causation?
   v. How exposure can be shown?
   vi. How the notice provision will operate?
   vii. Whether the last exposure rule will apply to traditional benefits?
   viii. If defendant insurers will have the ability to bring in other insurers to the claim?
   ix. How wages will be calculated for traditional benefits, permanent total disability benefits, and death benefits?
   x. When does the Statute of Limitations begin to run?

Notes Pages

Notes Pages

Notes Pages

DEFENDING OCCUPATIONAL DISEASE CLAIMS

I. Repetitive Trauma Injures/Occupational Disease

A. Defined in RSMo § 287.067

i. An identifiable disease arising with or without human fault out of and in the course of employment.
ii. The disease need not to have been foreseen or expected but after its contraction it must appear to have had its origin in a risk connected with the employment and to have flowed from that source as a rational consequence.
iii. Occupational diseases do not include ordinary disease of life to which the general public is exposed outside of the employment (287.067.1).
iv. If the disease follows as an incident of employment than it can be considered compensable.
v. Ordinary, gradual deterioration, or progressive degeneration of the body caused by aging or by the normal activities of day-to-day living shall not be compensable. (287.067.3).

B. What constitutes an Occupational disease?

i. An injury due to repetitive motion is recognized as an occupational disease (287.067.3).
ii. Loss of hearing due to industrial noise (287.067.4)
iii. Radiation disability (287.067.5).

C. Determining whether the claimant is alleging occupational disease:

i. The claim for compensation explicitly alleges a repetitive trauma injury or occupational disease.
ii. “Employee alleges injury to his bilateral hands/wrists stemming from repetitive use of his hands and wrists for working for Employer between 1989 to 2021”
iii. The date of loss listed will state “up until” a certain date or list a generalized time period such as “September 2020.”

D. Red Flags for Occupational Disease/Repetitive Trauma Claims

i. The Employer denies every being told about a specific accident or injury
ii. Multiple Employers are listed on the claim for compensation
iii. The claim for compensation does not list a specific mechanism of injury

E. Keys for communication with opposing counsel on potential occupational disease claims:

i. What is the mechanism of injury?
ii. To whom did the claimant report the injury?
iii. Where has the claimant sought medical treatment?

iv. Who is the claimant's primary care physician?
v. It is safer to use generalized language in order to avoid tipping opposing counsel off that they may have a repetitive trauma or occupational disease claim when they have filed a claim for an acute injury.
vi. If opposing counsel will not provide relevant information about the nature of the claim, options include requesting a pre-hearing or scheduling the claimant's deposition.

II. Investigation of occupational disease/repetitive trauma claims:

A. Employment history/job description
   i. Obtain the claimant's date of hire with the employer
   ii. Determine the claimant's prior work history e.g. resume or through deposition
   iii. Obtain a job description or description of the claimant's job duties
   iv. Determine the length of time with the employer
   v. Determine the coverage history with various insurance carriers

B. Symptom history/medical treatment
   i. Determine where the claimant has obtained medical treatment
   ii. Determine the claimant's primary care doctor
   iii. Use medical records/testimony to understand when the claimant's symptoms began
   iv. Determine the timeline for the progression of the claimant's symptoms
   v. Determine whether any healthcare providers have included information about the claimant's condition

C. Defense Strategy:
   i. Identify the appropriate date of occupational disease
      1. The date of injury listed on the Claim for Compensation is usually completely arbitrary
      2. The appropriate date provides guidance for the entire defense process

D. Determine the strength of a potential medical causation defense
   i. Job duties
      1. What does the claimant report about his/her job duties?
      2. What does the employer report about the claimant's job duties?
      3. Ergonomic analysis

E. Non-occupational risk factors
   i. Diabetes
   ii. Rheumatoid arthritis
   iii. Obesity
   iv. Sex
   v. Age

III. Evidence of Disability – when an occupational disease becomes compensable

A. An occupational disease does not become a compensable injury until the disease causes the employee to become disabled by affecting the employee's ability to perform his ordinary tasks and harming his earning ability. *Garrone v. Treasurer of State of Mo.* 157 S.W.3d 237, 242 (Mo. Ct. App. 2004).

B. Whether or not the employee misses work, if the injury is shown to have **harmed the employee's earning capacity**, is enough to constitute a disability under the workers' compensation statutes. *Feltrop v. Eskens Drywall and Insulation*, 957 S.W.2d 408 (Mo. Ct. App. 1997).

C. Evidence that may constitute evidence of disability (best to worst)
   i. The claimant missed work because of the occupational disease
   ii. The claimant did not miss work, but his/her output was tangibly affected because of the occupational disease. ex – claimant could not manufacture as many parts as prior to the occupational disease.
   iii. The claimant did not miss work, but he/she was placed on restrictions by a physician, and he/she had to work light duty because of the occupational disease.
   iv. The claimant was placed on restrictions but didn't actually adhere to the restrictions.

IV. The Last Exposure Rule:

A. The employer liable for the compensation in this section provided shall be the employer in whose employment the employee was **last exposed to the hazard of the occupational disease *prior to evidence of disability*,** regardless of the length of time of such last exposure. 287.063.2
   i. Example: If the claimant works as a mechanic for 10 years for Employer A, then works the same position for 1 year for Employer B and begins to miss work or performance is impacted by occupational disease, Employer B would be held liable.

B. The Exception to the Last Exposure Rule:
   i. With regard to occupational disease due to repetitive motion, if the exposure to the repetitive motion which is found to be the cause of the injury is for a **period of less than three months** and the evidence demonstrates that the **exposure to the repetitive motion with the immediate prior employer was the prevailing factor in causing the injury**, the prior employer shall be liable for such occupational disease. 287.067.8

ii. The exception is a two-part test:

1. The exposure to the repetitive motion which is found to be the cause of the injury is for a period of less than three months; AND
2. The evidence demonstrates that the exposure to the repetitive motion with the immediate prior employer was the prevailing factor in causing the injury.

iii. Exception Example:

1. The claimant worked for Employer A from 1/1/1995 to 12/31/2015 (20 years). The job duties for Employer A were very hand intensive.
2. On 1/1/2016, the claimant began working for Employer B. The job duties for Employer B were identical and hand intensive.
3. The claimant begins noticing numbness and tingling in his hands and wrists in February 2016. He goes to his primary care doctor on 2/1/2016 and is diagnosed with bilateral carpal tunnel syndrome. Surgery is recommended and the claimant is taken off of work. (evidence of disability).
4. The claimant was employed for less than 90 days with Employer B AND the repetitive motion with the immediate prior employer (Employer A) was the prevailing factor in causing the injury.
5. Employer A is most likely to be liable.

V. Defenses to occupational diseases/repetitive trauma injuries:

A. Notice – 287.420

i. No proceedings for compensation for any occupational disease or repetitive trauma under this chapter shall be maintained unless written notice of the time, place, and nature of the injury, and the name and address of the person injured, has been given to the employer **no later than thirty days after the diagnosis of the condition** unless the employee can prove the employer was not prejudiced by failure to receive the notice.

ii. Missouri Courts have interpreted the notice defense to only be applicable when a repetitive trauma diagnosis is made, and a medical causal connection between the diagnosis and the work exposure is provided. Once this occurs the 30-day notice time frame begins to run.

B. Statute of Limitations – 287.063.3

i. The statute of limitation referred to in 287.430 shall not begin to run in cases of occupational disease until it becomes **reasonably discoverable and apparent** that an injury has been sustained related to such exposure. . .

ii. “The apparent work-relatedness of an injury must be [the] paramount concern in answering the question of when the statute of limitations begins to run in occupational disease cases.” *Cook v. Missouri Highway and Transportation Commission*, 500 S.W.3d 917 (Mo. Ct. App. 2016).

VI. Investigations and Denials:

A. Non-litigated cases – employee reports the occupational disease

i. File the report of injury
ii. Take a recorded statement
    1. Determine the date of hire
    2. Job duties
    3. Job history
    4. Medical treatment
    5. Primary care physician
    6. Onset of symptoms
i. If there are no red flags, obtain an IME

B. Litigated Cases

i. Receive the Claim for Compensation
ii. Reach out to opposing counsel
iii. Reach out to employer
iv. Collect medical records
v. Speak with opposing counsel about adding other potentially liable employers and insurance carriers
vi. Take the claimant’s deposition
vii. Schedule an IME

Notes Pages

Notes Pages

Notes Pages

INDEPENDENT CONTRACTORS AND THE GIG ECONOMY

I. Independent Contractors

A. Definition**:** Independent Contractor – "one who, exercising an independent employment, contracts to do a piece of work according to his own methods, without being subject to the control of his employer, except as to the result of his work." Vaseleou v. St. Louis Realty & Sec. Co., 344 Mo. 1121, 130 S.W.2d 538 (1939).

i. Common guidelines as to what factors help determine if an individual is an independent contractor:

1. The company does not control and does not have the right to control what the worker does and how the worker does their job
2. The business aspects of the worker's job is not controlled by the payer (i.e., how worker is paid, whether expenses are reimbursed, who provides tools/supplies, etc.)
3. No written contracts or employee type benefits (i.e. pension plan, insurance, vacation pay, etc.)
4. No expectation that the relationship will continue
5. The work performed is not a key aspect of the business

ii. Not all these factors must be met. There are often factors that indicate that the worker is both an employee and an independent contractor. Look at the entire relationship between the parties and consider who maintains the right to direct and control.

B. Advantages of Using Independent Contractors

i. The employer will likely save money.

1. When hiring an employee, an employer will pay expenses that independent contractors do not require, like employer-provided benefits, their share of the employee's Social Security and Medicare taxes, state unemployment compensation insurance, and workers compensation insurance.

ii. The employer will likely reduce their exposure to state lawsuits.

1. Independent contractors are not protected by the many state rights that are given to employees. Some of these rights that are not available to independent contractors include (1) right to form a union (2) right to receive at least minimum wage/some overtime compensation (3) protection from employment discrimination, and (4) right to sue for wrongful termination.

iii. The employer will likely reduce their exposure to federal lawsuits.

1. Some federal labor laws exclude independent contractors from their scope. For example, independent contractors fall outside the extent of:

a. The Fair Labor Standards Act (FLSA), which establishes and enforces minimum wage and overtime pay requirements.
b. The National Labor Relations Act (NLRA), which guarantees employees the right to organize a union and bargain collectively.

iv. The employer will likely have more staffing flexibility.

1. When looking for a worker for a specific project or task, an independent contractor is a great option for employers because the contractor will be gone when the project is finished. Overall, with independent contractors, employers have greater leeway in hiring and firing workers.

II. Independent Contractors vs. Employees

A. The Gig Economy

i. As of 2018, more than 1/5th of the workforce in the U.S. was classified as independent contractors. Many of these people worked in what we now call the "gig economy", with many people holding positions at companies like Uber, Lyft, DoorDash, GrubHub, and TaskRabbit. Seth C. Oranburg, Unbundling Employment: Flexible Benefits for the Gig Economy, 11 Drexler L. Rev. 1 (2018).

ii. The gig economy encompasses various fields such as:

1. Art and design: Vampr (musicians), Fiverr (graphic design, videography)
2. Computer and information technology: Toptal (web developers), Upwork (computer programmers)
3. Construction and extraction: Thumbtack (painters), TaskRabbit (carpenters)
4. Media and communications: Trello (writers), Snappr (photographers)
5. Transportation and food service: Uber (drivers), DoorDash (food delivery)

B. Definition

i. Oxford Languages defines the gig economy as "a labor market characterized by the prevalence of short-term contracts or freelance work as opposed to permanent jobs."

ii. A gig can be defined as a single project or task for which a worker is hired to work on demand, often through a digital marketplace. Many workers pursue a gig as a self-employment opportunity that is easily accessible through websites or apps. One appeal of the gig economy is that a worker can work for numerous gig companies at one time (i.e., Uber and Lyft).

C. History and Background of the Gig Economy

i. Traditionally, the National Labor Relations Act of 1935 required workers to fit into two categories: employees or independent contractors. Labor law originally developed during the Great Depression when workers were forced to labor in harsh factory conditions. Now, labor law is evolving to accommodate this new age of technology, where labor focuses less on manufacturing and more on service.

ii. This new gig economy goes against the old dichotomy of employee versus independent contractor. In the gig economy, workers choose their hours and the services they want to perform, but they are not simply being contracted out like a traditional independent contractor. One issue with this new economy is figuring out what benefits, if any, are afforded to these gig workers.

iii. Some scholars propose that each firm that creates a platform to be used within the gig economy should register its own definition of a "gig worker" and submit it to the Department of Labor (DOL). This way, the DOL would decide what employment benefits are available to the gig workers who work for each individual firm. Others believe that creating a new third category of worker may be helpful, but the issue there is that the definition of "gig worker" is so mutable that one definition would fail to encompass all definitions in the future.

D. Current Events

i. The Fight Against Proposition 22

1. Proposition 22: This ballot measure was proposed by gig companies (most notably Uber) in California that wanted to reverse a 2019 law that narrowed the definition of independent contractors. Prop 22 passing would mean that gig workers would be classified as independent contractors and would not receive employment benefits like health care or state unemployment. But, if workers worked a certain number of hours per week, the companies would provide a health care subsidy and guarantee a minimum wage for the hours spent picking up riders (but not for time spent waiting for a fare). Prop 22 was passed in California due to the over $205 million spent by gig companies to promote the law.

2. Other States Involvement: Now, states like New York aim to prevent a law like Prop 22 from being passed. Local drivers and advocates, like the Independent Drivers Guild, want to pass legislation that gives drivers the right to bargain and negotiate benefits. The IDG aims to provide drivers with unemployment insurance, workers' compensation, and a livable wage. Although gig companies claim that laws like Prop 22 provide their workers more flexibility in choosing their hours, gig workers

are more focused on gaining the ability to unionize and to be provided employment benefits. Other states like Illinois are seeing a fight occurring between gig companies and their workers as more propositions are introduced that aim to deny gig workers employee status and the benefits that come with it. Aarian Marshall, Uber and Lyft's Gig Work Law Could Expand Beyond California,WIRED (22 Dec. 2020).

III. Gig Economy and Independent Contractors

A. Differences with Regular Employment

i. How independent contracting differs from regular employment:

1. More flexible: Contractors can take on work from various clients; they can choose which projects to accept.
2. Provides specialized services: Contractors don't need training, as they already have knowledge of a specialized industry.
3. Subcontractors: Contractors can hire subcontractors to assist them with a project.
4. Lack of benefits: Contractors do not usually receive traditional benefits like health insurance and retirement plans. They also do not benefit from the same legal protections as traditional employees.

ii. How gig working differs from regular employment:

1. More flexible: Gig workers can choose their own hours. They can even work one traditional job and work a gig on the weekends.
2. More variety: Many gig workers meet a variety of people day-to-day, and many people try out various gig jobs such as food delivery, transportation, and online writing/editing.
3. Inconsistency: Sometimes, starting a gig position is difficult because the worker may not have enough gigs to provide a stable income.
4. Lack of benefits: Gig workers do not usually receive traditional benefits like health insurance and retirement plans. They also do not benefit from the same legal protections as traditional employees. Although, this seems to be changing.
5. Temporary Employment Agencies (TEAs): TEAs provide workers to a variety of businesses through short-term contracts or temporary positions.
    a. Temporary workers are not the same as independent contractors. Temporary workers are technically classified as employees, although they often only work for about a year or less and are paid less than a regular employee. Independent contractors are not

classified as employees, and they create their own hours as long as they complete whatever task they were hired for.

b. Temporary workers are also different than gig workers. For instance, gig workers choose their own hours, and many people work multiple gig jobs at a time. Temporary workers, however, are more likely to receive employment benefits since they are classified as employees.

B. The Employer-Employee Relationship

i. Employer-Employee Relationship Test

1. Selection and engagement of the employee
2. Payment of wages
3. Power of dismissal
4. Power to control the employee (i.e., the means and methods by which the work is to be accomplished)

ii. If the employer only controls the end result of the work, there is no employment relationship.

iii. Traditional employment meets these factors, but independent contractors and gig workers do not.

C. Risks and Ramifications of Misclassifying Employees

i. IRS/Government scrutiny

1. State and federal agencies perform audits looking for workers who have been misclassified as independent contractors (oftentimes so the employer can avoid payroll taxes and workers' compensation/unemployment insurance costs).

2. Common penalties for misclassification include:

a. If intentional: (1) Penalties including 20% of all of wages paid, and 100% of the FICA taxes (2) criminal penalties of up to $1,000 per misclassified worker (3) possibly one year in prison.

b. If unintentional: (1) If employer failed to withhold income taxes, they face penalties of 1.5% of the wages, and 40% of the FICA taxes that were not withheld from the employee (2) a Failure to Pay Taxes penalty equal to 0.5% of the unpaid tax liability for each month (3) $50 for each Form W-2 that the employer failed to file.

ii. Loss of the "workers' compensation shield"

1. The workers' compensation "shield" is the idea that since workers' compensation provides employees with an opportunity to be compensated for work injuries, employees cannot then sue their employers for said injury.

2. When an employer misclassifies an employee, that "shield" is lost. Employee misclassification often results in substantial losses to state workers' compensation funds; thus, many states see misclassification as a substantial issue. So, some harsh penalties are implemented, like removing the workers' compensation shield so that the employee can sue.

iii. Insurance premium readjustment/audit

1. Some insurance companies do not include reclassified workers. This is in order to disavow financial responsibility for claims of reclassified workers, leaving that liability to the employer. In many cases of misclassification, insurance companies will also increase the insurance premium.

2. Independent insurance auditors audit employers' records on a selected basis to ensure that payroll, losses, and classifications are accurately reported. In some states, when a company has been found misclassifying workers, they are subjected to more audits to make sure the worker classifications are correct.

D. Workers' Compensation Issues

i. COVID-19

1. In most states, workers' compensation policies include occupational illnesses but not ordinary diseases. This policy is complicated by the emergence of COVID-19 because many in-person jobs may consider COVID-19 to be an occupational disease since it is transmitted through the air. We are now seeing a shift where traditionally low paying jobs (i.e., fast food workers, grocery store clerks, hotel staff) are now considered dangerous due to high exposure to COVID-19. Will this new classification of COVID-19 remain as a part of workers' compensation law, or will it disappear as the world recovers from COVID?

2. In Missouri and Kansas, it is difficult for employees to receive workers' compensation benefits after contracting COVID. They must show that the disease is occupational, and it is difficult to prove that the employee contracted COVID through their job and not in their day-to-day living.

ii. Growing Gig Economy

1. Gig workers and independent contractors are not guaranteed the same employment benefits and legal rights as traditional employees. As the gig economy grows, more gig workers are fighting for employment benefits. From 2010 to 2019, the share of gig workers increased from 14% to 16%, and the number of gig workers continues to grow. As technology advances and the gig economy expands, states will likely

have to consider adjusting their workers' compensation system to provide benefits to gig workers.

iii. Advancing Technology

1. Advancing technology can also affect how employees receive medical care through workers' compensation. Telehealth systems were created before COVID-19, but the pandemic helped to grow telehealth services and refine them so that they are easily accessible to all Americans. Employers can also benefit from telehealth services as their employees will likely pay less for telehealth visits than in-person visits, and the employee saves time by just using their computer or phone rather than traveling to a doctor's office. Overall, telehealth services reduce total medical costs, and employees can return to their jobs quicker. Telehealth services will likely expand as technology advances.

E. Subrogation Rights

i. Definition: Subrogation = "the substitution of one person or group by another in respect of a debt or insurance claim, accompanied by the transfer of any associated rights and duties. This is done in order to recover the amount of the claim paid by the insurance carrier to the insured for the loss." (Oxford Dictionary)

1. Ex: You get into a car accident (you are not at fault) with no injuries, but your car is damaged. Your insurance become subrogated to your rights and can make a claim against the other driver for repair cost for your car.

ii. Waiver

1. In contracts, subrogation can be waived. This means that the third party (i.e., insurance company) cannot seek damages from the party at fault. In employment law, it is common to see waivers of subrogation in construction contracts. These waivers are intended to prevent lawsuits, as it prevents insurance companies from seeking damages from the parties. Butler v. Mitchell-Hugeback, Inc., 895 SW2d 15 (Mo. 1995).

iii. Independent Contractors

1. Waivers of subrogation are often used in construction contracts because things can get complicated when contractors and subcontractors are involved. For example, if a subcontractor accidentally damages the property, subrogation would allow the general contractor's insurance to make a claim against the subcontractor. However, a waiver would prevent the general contractor's insurance from acting on their behalf. The insurance would simply pay the claim.

Notes Pages

Notes Pages

Notes Pages

KANSAS CITY, KS
10 E. Cambridge Circle Dr.
Suite 300
Kansas City, KS 66103
ph. 913.371.3838

ST. LOUIS, MO
505 N. 7th St.
Suite 2100
St. Louis, MO 63101
ph. 314.621.1133

SPRINGFIELD, MO
1546 E. Bradford Pkwy
Suite 100
Springfield, MO 65810
ph. 417.865.0007

DES MOINES, IA
4400 Westown Pkwy
Suite 490
West Des Moines, IA 50266
ph. 515.823.0800

SPRINGFIELD, IL
3201 W. White Oaks Dr.
Suite 200
Springfield, IL 62704
ph. 217.606.0900

OMAHA, NE
10665 Bedford Ave.
Suite 101
Omaha, NE 68134
ph. 402.408.1340

TULSA, OK
2021 S. Lewis
Suite 225
Tulsa, OK 74104
ph. 918.771.4465

KANSAS CITY, MO
2700 Bi-State Dr.
Suite 400
Kansas City, MO 64105
ph. 816.912.4446

Kansas • Missouri • Illinois • Iowa • Oklahoma • Nebraska • Arkansas

www.mvplaw.com