MVP Law Seminar 2023

WORKERS' COMPENSATION

KANSAS • MISSOURI • ILLINOIS • IOWA • OKLAHOMA • NEBRASKA

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, their claim will not be barred if their 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."

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
      a. Board and lodging if furnished by the employer
      b. Employer paid life insurance, disability insurance, health, and accident insurance
      c. 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 without testimony.
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 held 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. 44-510f

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. <u>Reduction for Pre-existing Impairments</u>
   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

(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

(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

        (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

        i. 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. <u>Permanent Total Disability</u>
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. <u>Death Cases</u> – 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, but leaves other dependents wholly dependent upon the employee's earnings (all other dependents)
    c. 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).
    d. 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).
        i. 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.

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 shall 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, but only out of extra compensation obtained by claimant.

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 their accident(s).
    c. Judge asks claimant if they are 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 they could hire an attorney.
        i. Explanation will detail that attorney could send claimant to a rating doctor of their choice – or claimant does not have to hire an attorney to get a rating from their 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

KANSAS WORKERS' COMPENSATION 201

HOW THE EMPLOYER CAN HELP ATTORNEYS IN WORKERS' COMPENSATION CLAIMS

I. Assist in Preparation of Contested Hearings

A. Preliminary Hearings

1. Witnesses
2. Evidence

B. Most Common Issues

1. Did the accident arise out of and in the course of employment?
    a) Job duties
        (1) Competent producing mechanism for this diagnosis?
    b) What happened?
        (1) Inconsistent history?
    c) Were there any witnesses?
    d) How and why did the accident occur?
        (1) Horseplay?
    e) When did the accident happen – date and time?
        (1) Did it even happen at work?
    f) Is there past medical history for the injured worker?
2. Notice
    a) Is there a designated person to receive notice of the accident?
    b) Was notice given?
        (1) When?
        (2) To whom?
        (3) Where did this take place?
        (4) What was said?
        (5) Was treatment authorized and provided?
3. Employment
    a) Was accommodated employment offered?
    b) Detail conversation:
        (1) Date of offer?
        (2) Verbal or written?
        (3) Who was present?

(4) Detail any conversation that occurred regarding employment after an accident.

c) Was there a resignation?
(1) Written?
(2) Verbal?

d) Unemployment?

e) Other employment?

f) Termination?

g) Personnel file?
(1) Date of hire?
*Is wage statement correct?
*Too short for repetitive motion?
(2) Reviews

C. Regular hearings
1. Witnesses
2. Evidence

II. Evidence

A. Personnel file
1. Evaluations

B. Wages
1. Calculate average weekly wage
2. Temporary benefits

C. Other valuable information regarding employee

III. Witnesses

A. Questions regarding accident:
1. Who was/is in charge?
2. Who saw the accident itself?
3. Who was told of the accident?
a) Notice prepared?

B. Employee's work status:
1. Able to accommodate restrictions?

C. If no longer employed:
    1. Witnesses to the circumstances of the Employee leaving the Employer.
        a) Voluntarily left
            (1) Able to accommodate restrictions?
            (2) Documented?
        b) Fired
            (1) Occurred after workers' compensation claim filed?
            (2) Able to accommodate restrictions?
            (3) Documented?

IV. Medical Information

A. Temporary or Permanent Accommodations
    1. Restrictions
    2. Maximum medical improvement
    3. Ratings
B. Employee's performance and communication with Employer
    1. Different than what they are telling the doctor?

Q: Was the Board correct to affirm the ALJ's award, pursuant to K.S.A. 44-510e(a)(2)(C), and adoption of one physician's findings that were based on a correct following of K.S.A. 44-510e(a)(2)(B) and relevant caselaw?

A: Yes, because the Board's affirmation reasonably supported how the relevant statutes and caselaw have been applied to workers' compensation issues.

Claimant, Ortega, was injured on 12/27/2017 while working as a licensed physical therapist for Encore. She needed two surgeries. She was unable to return to work following the surgeries, and applied for workers' compensation against Encore and its insurance carrier, Twin City Fire Insurance Co.

Two physicians testified to their evaluations of Ortega. Both physicians used the Fourth and Sixth Editions of the AMA Guides in determining their impairment ratings due to *Johnson v. US Food Service* being under review at the time of the ratings. Dr. Pedro Murati, in November 2019, found a 12% whole person impairment under Fourth Edition, and 8% whole body impairment under the Sixth Edition. Dr. Vito Carabetta, appointed by the ALJ, conducted an independent assessment in August 2020. Dr. Carabetta found Ortega to have a 10% whole body impairment under the Fourth Edition, and a 7% whole body impairment under the Sixth Edition.

The ALJ adopted Dr. Carabetta findings under the Fourth and Sixth Editions at 10% and 7%, respectively, but under *Johnson v. US Food Service*, awarded based only on the 7% impairment rating, so the ALJ did not find Ortega to reach the 7.5% threshold for work disability under K.S.A. 44-510e. Board review only affirmed the ALJ's decision by placing more weight on Dr. Carabetta's opinion than Dr. Murati's, and found that competent medical evidence established the 7% impairment rating.

On appeal, the KS Court of Appeals was responsible for determining if the Board erred in its review. Ortega argued that the Board failed to consider all the medical evidence on record by failing to consider Dr. Carabetta's impairment level under the Fourth Edition. The Court explained that use of *Garcia* was not applicable here, as that holding applies to a constitutional challenge. The reading of *Zimero* in light of *Johnson II* was the correct analysis. The Court reasoned that Dr. Carabetta's rating and analysis were more persuasive than that of Dr. Murati's. His findings reflected the proper reading of *Johnson II*, *Zimero*, and *Garcia* in using the Sixth Edition as the starting point of analysis as well as using his professional experience and judgment to determine the results.

The Court found that the Board did not err in its decision not to award Ortega work disability benefits.

Ortega v. Encore Rehabilitation Services LLC, 525 P.3d 21, 2023 WL 2194559 (Kan. Ct. App. 2023)

Q: Does the Kansas Court of Appeals have the jurisdiction to review an order from the Kansas Workers' Compensation Board if its order remanded back to the ALJ for further proceedings?

A: No, because the Court lacks jurisdiction to review a nonfinal agency action without meeting the requirements of K.S.A. 77-608.

Claimant, Pesina, worked for Aegis from July 2018 to September 2019. Pesina processed checks for around seven hours a day. Most work involved opening boxes or envelopes, and handling checks, with the occasional lifting of 20-pound boxes or pushing a cart with boxes on them. Her workload increased around the holiday season. She advised Aegis of hand wrist pain and numbness symptoms on January 16, 2019, and applied for workers' compensation on February 5, 2019. She left Aegis in September 2019 and began working at Kansas Neurological Institute. There, she cared for developmentally disabled adults. Around February or March 2020, Pesina began to feel pain in her elbow, but did not report injury to Aegis.

At the request of Aegis, Pesina underwent an independent medical evaluation (IME) on February 28, 2019, by Dr. Robert Bruce. Dr. Bruce opined that that Pesina's wrist injury was the only injury caused by her work at Aegis. Additionally, he opined that Pesina did not have carpal tunnel on either side. He determined Pesina to be at MMI with 0% impairment, and that she would not need any future medical treatment.

Dr. Brian Divelbiss performed a court-ordered IME of Pesina on July 2, 2019. He concluded that Pesina's work for Aegis was not the prevailing factor for any of her symptoms, but rather it was because of aging, gender, hypothyroidism, or a combination of them.

At request of Pesina's counsel, Dr. Daniel Zimmerman evaluated Pesina on February 19, 2020. Dr. Zimmerman found Pesina to have multiple diagnoses to both left and right extremities, and her work duties at Aegis were the prevailing factor for those diagnoses. Dr. Zimmerman rated Pesina at 4% impairment to the whole person under the Sixth Edition.

On June 7, 2021, the ALJ issued an award to Pesina of 2% impairment to the right wrist, referencing Dr. Zimmerman's rating. The ALJ awarded nothing for "alleged bilateral carpal tunnel," and no future medical treatment was awarded. Lastly, the ALJ found that her elbow injury did not arise out of and in the course of employment at Aegis.

Pesina requested the Board to remand for presentation of additional evidence. The Court relied on *Adam v. Ashby House Ltd.*, No. AP-00-0455-555, 2021 WL 1832461 (Kan. Work. Comp. App. Bd. April 26, 2021). There, the board granted remand because no party was in a position at that time to predict the nature of claimant's injury. Here, the Board vacated the ALJ's award and remanded the case for parties to present additional evidence to determine the nature and extent of Pesina's injuries. Aegis petitioned for review of the Board's order.

The Court of Appeals determined the Board's decision to be one that is considered nonfinal, stating that the Board clearly intended for the order to be "preliminary, preparatory, procedural or intermediate" in nature, and incidentally not subject to immediate judicial review.

Aegis argued that the Board's remand was unlawful, and therefore appealable, however K.S.A. 44-551(l) clearly permits the Board to remand "any matter" to the ALJ for further proceedings. Additionally, Aegis argued that even if the decision was nonfinal, it is still appealable under K.S.A. 77-608. In order for the statute to apply, it must pass the requirements of both 77-608(a) and (b). Pesina conceded that it passes 77-608(a) requirements.

K.S.A. 77-608(b) reads as follows:

> A person is entitled to interlocutory review of nonfinal agency action only if: … (b) postponement of judicial review would result in an inadequate remedy or irreparable harm disproportionate to the public benefit derived from postponement.

Respective to this statute, Aegis argued that postponing judicial review would result in irreparable harm or an inadequate remedy, but the argument fails to acknowledge K.S.A. 44-551(l)(1) that allows any matter to be remanded to the ALJ for further proceedings. Additionally, Aegis argued that "there will be no public benefit derived from postponement" because delay of resolution in this case will only encourage other litigants to do the same. However, the Court reasons that the main issue in this case is still unresolved, which is what compensation Pesina could receive for work injuries, and that would be more injurious to the public than remand.

This Court affirmed the Board's remand back to the ALJ for further proceedings. The order was a nonfinal agency action, and this Court does not have the jurisdiction to review such an order. Aegis' appeal was dismissed without prejudice.

Pesina v. Aegis Processing Solutions, 514 P.3d 400, 2022 WL 3330477 (Kan. Ct. App. 2022)

Q: When a claimant receives workers' compensation benefits from his employer, will the dual capacity doctrine apply as to civil liability to claimant's employer?

A: No, the dual capacity doctrine will not apply to a claimant's employer that already provides workers' compensation benefits.

Claimant Jason Jeffries was receiving workers' compensation benefits from his employer, United Rotary Bush Co. (URBC), after getting injured at work. He then filed a civil suit against URBC alleging negligent design and manufacture of the machine that he was operating at the time of injury. Jeffries claimed URBC was civilly liable under the dual capacity doctrine, which is a judicially recognized exception to the exclusive remedy provision of the Workers' Compensation Act. The case was dismissed on summary judgment by the District Court finding that the dual capacity doctrine does not apply when

the employer providing workers' compensation benefits is also the manufacturer of the machine that injured the employee.

The exclusive remedy provision, K.S.A. 44-501b(d), provides: "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 ...." (Emphasis added.)

Essentially, this doctrine means that an injured employee cannot maintain a civil suit against his employer for common law negligence if that employee is recovering, or could have recovered, workers' compensation benefits from his employer.

An exception to this remedy is the dual capacity doctrine, established in *Kimzey v. Interpace Corp.*, 10 Kan. App. 2d 165, 694 P.2d 907 (1985), which allows for an employee who is, or could be, receiving workers' compensation benefits from their employer, to maintain a civil suit against that employer or a third-party tortfeasor. If brought against the employer, the employer must occupy a second capacity that imposes obligations independent of those as the employer.

Jeffries argues two points: (1) a 2008 transaction involving URBC was not a merger, so URBC was conferred third-party obligations to Jeffries; and (2) if the 2008 transaction was a merger, then the dual capacity doctrine applies because the emerging entity assumes liabilities of the pre-existing entities.

The Court of Appeals rejects Jeffries' arguments. The Court ruled that the 2008 transaction in question was in fact a merger, and therefore no new entity was created, and so no additional liability was created or conferred upon URBC. Moreover, the dual capacity doctrine does not apply here because Jeffries' injury stemmed from operation of a URBC-manufactured machine, no additional/third-party liability was conferred upon URBC.

The Court of Appeals affirmed the District Court's ruling, stating their decision was reasonable and not an abuse of discretion.

Jefferies v. United Rotary Brush Corporation, 62 Kan.App.2d 354, 515 P.3d 743 (Kan. Ct. App. 2022)

Q. *Is the Kansas Workers' Compensation Act's exclusive remedy provision triggered when one company contracts out work to another and an employee of the subcontractor company dies on its premises while performing the work?*

A. Yes. The Kansas Workers' Compensation Act is broadly construed in terms of who comes under the coverage of the Act.

Scott's Welding Service, Inc. ("SWS") performed general fabrication, welding, and machine shop services. SWS contracted with a buyer, agreeing to manufacture and assemble three poly pipe trailers. SWS contracted out the painting of the trailers to Blackhawk Sandblasting and Coating, LLC ("Blackhawk"). Scott Stein, decedent, was

painting the trailers when one of them collapsed on him and killed him. The accident occurred on Blackhawk's premises.

Decedent's estate, Tara Stein, and the Steins' child sued SWS for negligence, alleging that SWS's failure to install a safety brace before providing the trailers to Blackhawk caused decedent's death. The district court granted SWS's motion for summary judgment. It held that the Kansas Workers' Compensation Act ("KWCA") barred the Steins' tort suit because SWS qualified as a statutory employer under K.S.A. 44-503(a). The Steins' appealed.

On appeal, the Steins' argued that SWS was not decedent's employer for purposes of KWCA coverage and that the statutory employer defense is not available to SWS because the accident did not occur on property under its control. The Kansas Court of Appeals affirmed the district court's decision.

The Court reasoned that the Kansas Legislature intended the KWCA to be liberally construed when it comes to coverage under the Act. K.S.A. 44-503(a) provides that an employer who contracts out contracted work is a statutory employer under the KWCA. Since SWS contracted out the painting work for the trailers to Blackhawk, SWS comes within the coverage of the KWCA as a statutory employer. As such, the Steins' negligence suit against SWS is barred, and the benefits within the KWCA are their only recourse for decedent's work-related death.

The Steins tried to argue that even if SWS is found to be statutory employer within the meaning of the KWCA, an exception nonetheless applies because the accident did not occur on premises SWS controlled. The Court shut down this argument as well because the Kansas Supreme Court has long-held that "in or about the premises on which the principal has undertaken to execute work" should be broadly construed to "include nearly anywhere where an injured claimant is working on behalf of the principal." Even though the decedent was on Blackhawk's property, the fact that he was performing the painting job for SWS meant that SWS was still a statutory employer under the KWCA.

Therefore, the KWCA's exclusive remedy provision is triggered, and the Steins' tort action against SWS is barred.

Est. of Stein by & through Stein v. Scott's Welding Serv., Inc., 508 P.3d 407 (Kan. Ct. App. 2022)

Q*. When a claimant files a workers' compensation claim and a federal lawsuit against his employer's uninsured motorist carrier of which the Kansas Workers' Compensation Fund is unaware, does K.S.A. 44-504 entitle the Kansas Workers' Compensation Fund to a subrogation credit on the settlement of the federal suit?*

A. Yes. K.S.A. 44-504(b) permits the Fund to attach a subrogation lien to a settlement in a separate "action against a third party that is legally liable to pay damages for the same injuries as those claimed in the workers' compensation action."

On December 12, 2016, Kendall Turner sustained a thoracic spine injury from a head-on collision while driving a truck hauling grain for Pleasant Acres LLC.

Mr. Turner sustained a previous back injury while working for a different employer about 25 years ago. He fell from a 15-foot stock tank and injured his low back. Additionally, a pinched nerve caused him to experience pain from his right shin to right ankle.

Mr. Turner filed a workers' compensation claim against Pleasant Acres LLC, who did not have workers' compensation insurance at the time of the accident. He subsequently impleaded the Kansas Workers' Compensation Fund ("the Fund") pursuant to K.S.A. 2016 Supp. 44-532a(a).

Unbeknownst to the Fund, Mr. Turner also filed a lawsuit against Continental Western Insurance Company ("Continental") in Kansas federal court. Continental served as Pleasant Acres' uninsured motorist coverage carrier. Mr. Turner alleged that the negligence of the other driver involved in the collision was what caused the vehicle collision. He claimed he suffered injuries to his spine and back and asked for damages including "pain and suffering, mental anguish, loss of time, loss of enjoyment of life, medical expenses, economic loss, permanent disfigurement, and permanent disability."

Mr. Turner and Continental reached a settlement agreement in which Mr. Turner agreed to the payment of $230,000.00 in exchange for releasing all claims arising out of the injuries, damages, and losses sustained by him in the 2016 accident. This federal lawsuit was settled without giving notice to the Fund. The Fund learned of Mr. Turner's settlement of the federal case at the regular hearing on his workers' compensation claim on June 11, 2019.

The ALJ denied the Fund's request for a subrogation credit under K.S.A. 44-504. The Fund appealed this finding, among others, to the Kansas Workers' Compensation Appeals Board ("the Board"), which affirmed the ALJ's findings in whole. The Fund appealed the Board's decision to the Kansas Court of Appeals.

The Court of Appeals' analysis involved interpreting K.S.A. 44-504. The statute serves two purposes: (1) preserve an injured worker's right to bring a claim for damages against a third party who caused the injuries; and (2) prevent double recovery for the same injuries.

The Court, first, found that the statute does not distinguish between the types of recovery the employer, or the Fund standing in the employer's shoes, can subrogate. Therefore, judgments and settlements for both tort and contract claims against third parties are subject to subrogation. Then, the Court held that the Fund can subrogate the amount of Mr. Turner's federal claim settlement to the extent of the compensation and medical aid awarded in his workers' compensation action. However, any portion of the settlement that was for loss of consortium or loss of services to a spouse is not subject to subrogation. These holdings carry out the Kansas Legislature's intent in preserving an injured worker's right to be compensated for work-related injuries but preventing double recovery.

The case was remanded to the Board to determine how much of Mr. Turner's settlement could be subrogated.

Turner v. Pleasant Acres LLC, 62 Kan. App. 2d 122, 125, 506 P.3d 963 (2022).

Q. *Can the Kansas Workers' Compensation Fund sue a general contractor to recover funds paid because of an insolvent subcontractor?*

***A.* Yes. When multiple potential employers are involved, specifically a principal and a subcontractor, who qualifies as an "employer" under K.S.A. 44-523a is not restricted to just one or the other.**

A construction general contractor (principal), Trademark, Inc., hired a subcontractor, Ballin, for a project. One of the subcontractor's employees, Juan Medina, sustained a compensable workers' compensation claim. The subcontractor did not carry workers' compensation insurance, so Medina impleaded the Kansas Workers' Compensation Fund. The ALJ awarded Medina compensation that the Fund had to pay.

The Fund subsequently filed a collateral action under K.S.A. 2020 Supp. 44-532a seeking reimbursement from the principal, who was not involved in the workers' compensation claim. The district court granted summary judgment for the Fund, and Trademark appealed. The district court also denied an award of attorney's fees for the Fund, which it cross-appealed. The Kansas Court of Appeals affirmed both decisions. The Kansas Supreme Court affirmed as well.

The principal argued that it was not Medina's "employer" as defined by K.S.A. 2020 Supp. 44-532a. The Kansas Supreme Court rejected this argument in holding that the Fund may assert the reimbursement action against either the insolvent employer (the subcontractor), or the solvent statutory employer (the principal), or both.

Schmidt v. Trademark, Inc., 506 P.3d 267 (Kan. 2022)

Q: *Does the Board have the authority to stay a workers' compensation proceeding in anticipation of a potential change in the controlling law?*

A: Generally, yes. Only if such a stay has been formally requested by the parties.

In *Guzzo v. Heartland Plant Innovations*, the ALJ considered the evidence of two physicians and determined Guzzo's impairment based on the AMA Guides 6th Edition opinion of the physician retained by Guzzo. Notably, this decision came down during the time period when the Supreme Court decision in *Johnson v. US Food Service* was still pending. Both parties appealed the decision on several issues, including whether the Sixth Edition mentioned in the Workers' Compensation Act is unconstitutional, whether Guzzo met her burden of proof in establishing need for future medical compensation, and the nature and extent of Guzzo's impairment. During oral arguments before the Appeals Board, a member of the Board asked the parties whether they wished to stay the proceedings until the Supreme Court decided *Johnson*. Guzzo agreed to a stay, but Heartland opposed it. Neither party formally requested a stay. In its decision, a majority of the Board found it lacked authority to issue a stay under K.S.A. 77-616(a) and K.S.A.

2020 Supp. 44-556(b). Guzzo timely appealed, arguing in part that the Board erred in finding that neither the Workers Compensation Act, K.S.A. 44-501 et seq., nor the Kansas Judicial Review Act (KJRA), K.S.A. 77-601 et seq., authorized it to stay workers compensation proceedings in anticipation of a potential change in the controlling law by the Supreme Court.

The Court of Appeals found that since Guzzo did not formally request a stay, she could not complain on appeal about the Board's failure to issue one. In coming to this conclusion, the Court noted that the KJRA states an agency may grant a stay on appropriate terms during judicial review. K.S.A. 77-616(a). By allowing the Board to "grant" a stay, the statute implies that there must first be a request to grant made by one of the parties. See K.S.A. 77-616(b). In Guzzo, neither party officially requested a stay from the Board so the issue was not preserved for appeal.

Guzzo v. Heartland Plant Innovations Inc., 490 P.3d 85 (Kan. Ct. App. 2021)

Q*. Did Kansas Supreme Court Administrative Order 2020-PR-016, which tolled statutes of limitations and deadlines to accommodate the COVID-19 pandemic, apply to workers' compensation proceedings?*

A. No. Order 2020-PR-016 does not apply to workers' compensation proceedings.

Tyler Haney alleged that he injured his shoulder while working as a police officer for the City of Lawrence. After Mr. Haney's attorney withdrew from representing him, he proceeded pro se at the preliminary hearing. The administrative law judge ("ALJ") found that Mr. Haney failed to prove that his alleged work injury was the prevailing factor causing his medical condition, need for treatment, or resulting impairment. The ALJ cautioned Mr. Haney about the upcoming deadlines since he was representing himself at the time.

Mr. Haney failed to take the matter to a regular hearing one year after the preliminary hearing as required by K.S.A. 2020 Supp. 44-523(f)(2). The City of Lawrence sought to dismiss the case. During a telephone hearing on the City's application, Mr. Haney stated that he had been working on finding an attorney. The ALJ gave Claimant a few weeks to do so.

Mr. Haney retained an attorney who filed a response brief on Haney's behalf. Mr. Haney argued that the Kansas Supreme Court Administrative Order 2020-PR-016 applied to workers' compensation proceedings and that the COVID-19 pandemic constituted good cause to extend the one-year deadline Mr. Haney missed. The ALJ rejected these arguments in granting the City's application for dismissal. The Board affirmed.

The Kansas Court of Appeals affirmed the Board's decision. It found that the Board correctly interpreted Order 2020-PR-016 to not apply to workers' compensation proceedings. While the Order applies to "judicial proceedings," the context of the entire order reveals that only proceedings in Kansas state courts are contained within this term. Therefore, workers' compensation proceedings do not count.

The COVID-19 pandemic was not a good faith reason for extending Mr. Haney's one-year deadline because he never explained how the pandemic had hampered his efforts. Furthermore, there is no evidence that Mr. Haney made any effort after the preliminary hearing to move his claim to a regular hearing.

Haney v. City of Lawrence, 507 P.3d 1150 (Kan. Ct. App. 2022).

Q: *When determining whether a claimant is entitled to work disability, do actual earnings constitute earning capacity if the Claimant's new employment includes periods with special assignments or projects where pay is at a higher level?*

A: Generally, Yes.

Four months into his employment, Williams injured himself. Williams received treatment and when he was released from care he was provided permanent restrictions. However, because his employer, Wellco, could not accommodate any permanent restrictions, it terminated Williams' employment. The doctors assigned him a 25% functional impairment of the body as a whole under the AMA Guides 6th Edition. Because his functional impairment was greater than 10%, Williams could qualify for ongoing disability payments if he suffered a post-injury wage loss of at least 10% because of the work injury.

Following his termination and medical release, Williams secured employment with Long Trucking, LLC. Long agreed to hire him as a full-time truck driver for $16 per hour, but limited Williams' duties strictly to driving and told him violation of the medical restrictions would be cause for termination. The availability of hours for Williams varied according to the season and weather, so some weeks Williams did not work at all but others he worked at least the full 40 hours. Further, for 11 days that year, Williams and other employees at Long Trucking, LLC were assigned to help clean up a natural disaster in Missouri and were paid the "prevailing wage" of $30 per hour. During this time, Williams also worked longer hours. Using the total pay Williams earned following his termination from Wellco, the two weeks of uncommon federal pay pushed his income loss to only 9%. Williams retained counsel and argued that he was entitled to ongoing disability as his actual earning did not constitute his earning capacity. However, the ALJ determined Williams could not overcome the presumption that his actual earning constituted his earning capacity and therefore he was not entitled to any disability payments. Williams appealed this decision.

Williams made two arguments before the Board that his actual earnings did not constitute his earning capacity: (1) that the truck driving position with Long Trucking was an accommodated position that did not exist in the open market; and (2) that he received a higher than usual rate of pay and worked excessive overtime hours during the two-week period, making those wages unique and not reflective of his earning capacity. For the first argument, the Court agreed with the Board's finding that there was no evidence to suggest that Williams' job with Long Trucking was an accommodated position that did not exist in the open market. As for the second argument, the Court opined that the statute (K.S.A. 2020 Supp. 44-510e(a)(2)(E)) still requires calculating the difference between pre-

injury average weekly wage and post-injury average weekly wage. The Kansas Supreme Court's disapproval of cherry-picked weeks when comparing pre- and post-injury average weekly wage remains intact even with the 2011 amendments because the Board is still required to consider actual earnings when they are available. Further, the Board concluded that the new work Williams completed over a two-week period may have been unusual, but it was work that all his coworkers also performed. So it was appropriate to impute those wages. The Court found evidence in the record to support the Board's conclusion.

Williams v. Wellco Tank Trucks, Inc., 491 P.3d 660 (Kan. Ct. App. 2021)

Q*. What is the personal comfort doctrine and when is an injured worker considered outside the scope of his employment when on a break?*

A. The personal comfort doctrine is when an employee engages in acts which minister to personal comfort but do not leave the course of employment. In some cases, the activity is considered inherent in the work despite its personal risk. In example, walking to use the restroom, smoking during a break, grabbing a cup of coffee may not be part of someone's job, but are permissible activities which may lead to workplace injuries.

In this case, an employee was on break and elected to move his motorcycle from an illegally parked handicap parking spot to another parking spot. In the process, he fell from his motorcycle and sustained an injury. The Court of Appeals affirmed the lower court's decision that there were sufficient facts demonstrating the Employer allowed employees to move vehicles during their break and such an activity benefitted the Employer because it was improperly parked. Further, the Court indicated the Employer retained control over the employee because he was required to remain on the premises and was on call via his radio. Thus, the Court maintained the employee's responsibilities to the Employer continued through his break in which he sustained an injury.

In this unpublished opinion, the Kansas Court of Appeals expanded its definition of the personal comfort doctrine holding that moving a personal motorcycle during a break and falling was within an employee's course of his employment because the Employer maintained control over the Employee.

Thach v. Farmland Foods, Inc., 2021 WL 5990059 (Kan. Ct. App. Dec. 17, 2021) (unpublished decision)

Q. *What is the standard an employer must demonstrate to determine if an employee is terminated "for cause" to disallow wage loss in a work disability claim before an Administrative Law Judge or the Kansas Workers Compensation Board?*

A. An Administrative Law Judge and the Kansas Workers Compensation Board shall evaluate whether the termination was **reasonable, given all the circumstances**. The Court shall consider whether the claimant made a good faith effort to maintain his or her employment and the employer exercised good faith. **The primary focus should be to**

determine whether the employer's reason for termination is actually a subterfuge to avoid work disability payments.

While an injured workers' compensation claim was pending, he was terminated for violating work restrictions imposed by his doctor. His supervisor observed him kneeling, reaching under a table to retrieve a glove off the floor with a long hook. However, his work restrictions prohibited kneeling. The termination followed his third write-up within the year. The Administrative Law Judge found the employee was not entitled to temporary total disability benefits because he had been terminated for cause. The Board modified the Award, finding the employer was simply getting rid of a troublesome employee to avoid paying work disability. Ultimately, the Board held the employer did not terminate the employee in good faith, but as a subterfuge to avoid work disability. The Court of Appeals held the evidence considered by the Board, including each of the three write-ups, was sufficient evidence to support the finding the injured worker was entitled to work disability payments.

Oliver v. National Beef Packing Co., 2021 WL 5984170, (Kan. Ct. App. Dec. 17, 2021) (unpublished opinion)

Q. *When an injured employee files a claim for an accident and proceeds to a Hearing before an Administrative Law Judge, is the employee precluded from bringing a new repetitive trauma claim to the same body part?*

A. No. The Kansas Court of Appeals held a firefighter was not barred from bringing a repetitive trauma claim for his hearing loss because he lacked evidence to bring the repetitive trauma claim at the time he litigated his single accident claim.

In this case, Patrick O'Neal filed a workers compensation claim alleging bilateral hearing loss and tinnitus stemming from a fire truck's air horn going off inside the fire station from a single event on February 23, 2009. Per Kansas law, this was filed as a "single accident." Following May 10, 2016 testimony by the medical expert on behalf of the employer, O'Neal filed a new claim alleging repetitive trauma from his employment as a firefighter caused hearing loss at the time his accident claim was pending on July 11, 2016.

The Employer argued Mr. O'Neal was barred from raising the repetitive trauma claim because it could have been brought at the time of the first claim. The legal challenge is called "res judicata" or "claim preclusion." As explained by the Kansas Court of Appeals, a claim is precluded if four elements are satisfied: (1) the same claim; (2) the same parties; (3) claims that were or could have been raised; and (4) a final judgment on the merits. If any element is not met, res judicata does not apply. The Kansas Court of Appeals held the claims did not meet the first and third element. First, the repetitive trauma claim was not the same as his single accident claim. Second, Mr. O'Neal did not have any knowledge at the time of filing his single accident claim that his injuries were caused by repetitive trauma and his window had closed to add evidence in his single accident claim had closed. Thus, Mr. O'Neal was not precluded from raising his repetitive trauma claim. The Court of Appeals additionally ruled the employer was on notice of the

repetitive trauma because their expert provided the opinion and they had evidence dating back to 2002 of his hearing loss.

O'Neal v. City of Hutchinson, 2021 WL 5408630 (Kan. Ct. App. November 19, 2021) (Unpublished opinion)

Q. *When an Administrative Law Judge grants a motion for extension to proceed to hearing following three years of an application for benefits and the timeframe for that extension expires, does the injured worker waive his or her rights to proceed to a Hearing?*

A. No. The Court of Appeals held there is no law concerning a second motion to extend the deadline for a Regular Hearing following an application for benefits.

The Court previously interpreted failure to have a Regular Hearing or settlement within three years is a time bar. *Glaze v. J.K. Williams*. In this case, the Court of Appeals distinguished the previous ruling and interpreted K.S.A. 44-523(f) when there is a previously granted motion for extension. Ultimately, the Court of Appeals allowed for an open-ended interpretation by the Administrative Law Judge concerning whether there is good cause for a second extension of time per K.S.A. 44-523(f), even after the time lapsed for the first extension.

On November 24, 2014, Claimant alleged a work accident to her knee. On May 29, 2015, Claimant filed an Application for Hearing with the Division of Workers Compensation. Before the statutory deadline of May 29, 2018, Claimant moved to extend the time for Hearing under KSA 44-523(f)(1) (2016) because she had not yet reached maximum medical improvement. The ALJ issued an Agreed Order (approved by the parties) extending the deadline for a Regular Hearing to November 29, 2018. The deadline passed without action from the parties. Respondent moved to dismiss the claim while Claimant moved to extend the deadline because she had not yet reached MMI. The ALJ denied the motion to dismiss and granted the motion to extend time. A Regular Hearing was held and the ALJ awarded compensation in July 2020. Respondent appealed the award arguing the ALJ erred by extending the time for a hearing and by not dismissing the claim.

The Board affirmed the ALJ ruling that **once Claimant established good cause to extend the deadline by filing her first extension then her claim remained viable until good cause no longer existed**.

The court evaluated the issue under, KSA 44-523(f)(1), upon filing a second motion for extension outside of the timeframe allowed, did the ALJ improperly grant such an extension? The Court determined KSA 44-523(f) only contains two conditions to keep a claim viable: (1) Claimant must file a motion to extend prior to the expiration of the three-year limitation; and (2) good cause must exist for the claim to be extended. Under this threshold, Claimant met both conditions. The Court found the statute only takes into consideration one motion to extend, not multiple motions. Despite the argument presented by Respondent that a second extension should have been filed prior to the

expiration of the first extension's expiration, the Court found no such statutory requirement.

The statute is silent concerning multiple motions to extend, so the Court of Appeals affirmed the Board's determination that there were only two requirements necessary to keep Claimant's claim viable: (1) moving to extend the deadline within the three-year limit; and (2) showing good cause for an extension.

Gerlach v. Choices Network, --- P.3d --- 2021 WL 5264318, (Kan. Ct. App. November 12, 2021) (Choices Network did not file a petition for review).

Q. *Can a criminal court order restitution to an insurance carrier for the medical benefits provided to the victim of a crime?*

A. Yes, where a district court awarded criminal restitution in the amount of medical benefits to the insurance carrier, the Kansas Supreme Court upheld the award as permissible. The defendant argued the award was violative of his constitutional right to a jury trial, and the Court severed the portions of the statute violative of his constitutional rights.

In this case, Mr. Robison was charged with two counts of battery of a law enforcement officer. Mr. Robison injured Corporal Bobby Cutright to the point Cutright required medical treatment from Newman Regional Health. Lyon County's insurance carrier covered Corporate Cutright's medical bills. The District Court agreed to consider the State's request for restitution and ordered Mr. Robison to pay restitution in the amount of $2,648.56 to reimburse the workers compensation insurance carrier for medical expenses paid. Defendant challenged the award of medical expenses as violative of his constitutional right to a jury trial.

Through a statutory and constitutional analysis, the Kansas Supreme Court held the criminal restitution awarded was not violative of Mr. Robison's right to a jury trial to determine damages. The Court held there is a distinction between the civil damages and criminal restitution. Within this difference, criminal restitution is recognized as rehabilitative because it forces a defendant to confront, in concrete terms, the harm his actions have caused. A defendant cannot foreclose restitution in a criminal case through execution of a release of liability or satisfaction of payment by the victim. Ultimately, the Kansas Supreme Court held a court may enforce its order of a criminal restitution through lawful means if the court has cause to believe a defendant is not in compliance. The Court decided criminal restitution does not violate the Kansas constitution's right to a jury trial and severed relevant portions of the statute that would violate such right.

State v. Robison, 496 P.3d 892 (Kan. 2021).

Q. *What is the significance of the continued reference to the A.M.A. Guides, Fourth Edition within the Kansas Workers Compensation Act?*

A. The Kansas Court of Appeals held any reference to the A.M.A. Guides, Fourth Edition occurring after January 1, 2015 is irrelevant and use of the A.M.A. Guides, Sixth Edition is "statutorily required."

In this claim, the injured worker sustained a bilateral upper extremity injury where his expert had provided impairment ratings per both the A.M.A. Guides Fourth and Sixth Editions. He argued the A.M.A. Guides, Fourth Edition should be taken into consideration to adequately consider "competent medical evidence." The Court of Appeals explained the parties and courts do not choose between using the Fourth Edition or the Sixth Edition. Rather, the Sixth Edition is statutorily required.

Zimero v. Tyson Fresh Meats, --- P.3d --- (Kan. Ct. App. 2021).

Q. When an employee sustains a work-related accident which led to a medial meniscal repair, but the accident was determined not the prevailing factor for the employee's need for a total knee replacement – does the fact a work-related injury renders preexisting arthritis symptomatic render the total knee replacement compensable?

A. No. The Court of Appeals proceeded with an evaluation of the prevailing factor test with the secondary injury rule noting statutory language: "an injury is not compensable solely because it aggravates, accelerates, or exacerbates a preexisting condition or renders a preexisting condition symptomatic."

Further, the Court said, all injuries, including secondary injuries, must be caused primarily by the work accident. Specifically, "the Board has traditionally denied total knee replacement surgeries when it has found preexisting arthritic conditions, not the work-related accident, caused the need for the knee replacement."

An additional important note within this case was the determination that the American Medical Association Guides to the Evaluation of Permanent Impairment may be judicially noticed by the Court of Appeals because it would be unnecessary to require an administrative law judge to require admission of the Guides into evidence in every single workers compensation hearing given "there is no disputing their content." Additionally, the Court additionally found the decision did not violate the Employee's constitutional rights because he still had an adequate substitute remedy available.
Perez v. National Beef Packing Co., 494 P.3d 268 (Kan. Ct. App. 2021).

Q*. Can the Kansas Workers Compensation Fund sue a general contractor to recover funds paid because of an absolvent subcontractor?*

A. Yes.

A construction general contractor (principal) hired a subcontractor. One of the subcontractor's employee's sustained a compensable workers' compensation claim. The subcontractor did not have workers' compensation insurance and the employee recovered workers' compensation benefits from the Kansas Workers Compensation Fund per an award from an Administrative Law Judge. The Kansas Workers Compensation sued the principal, who had not been involved in the workers' compensation claim, seeking recovery of costs paid to the employee and attorney's fees.

The Kansas Court of Appeals held the Workers Compensation Act mandates that a principal contractor is liable for the payment of workers compensation when its

subcontractor is uninsured or insolvent. The primary aim of the Act is the prompt payment of claims for injured workers. However, on the issue of attorney's fees, the court held there is no statute which would authorize an attorney fee payment to the Fund and the lower court had correctly denied the Kansas Fund's motion for attorney fees.

Schmidt v. Trademark, Inc., 493 P.3d 958 (Kan. Ct. App. 2021).

Q: Whether the statute of limitations for an assigned claim of breach of contract against an insurance company and its agent for failing to procure desired insurance coverage begins running at the time of the breach by the insurance company, or at a later date when the assignee discovers the breach?

A: Yes, it begins running at the time of the breach, not the discovery.

When bringing a claim for breach of an oral contract for procurement of insurance coverage, the three-year statute of limitations period begins to run when the breach occurs, not when the injured party or assignee is harmed by the breach. *Dupass v. Kansas Ins., Inc.*, 491 P.3d 660 (Kan. Ct. App. 2021), *review denied* (Dec. 6, 2021).

In *Dupass*, the plaintiff of the original action, Dupass, was severely injured in a motor vehicle accident caused by another driver, Woofter. Woofter thought his vehicle was covered by a $1,000,000 liability policy, but during discovery found it was only covered by a $100,000 motor vehicle policy. In the original Arizona lawsuit, Dupass was granted a $500,000 judgment against Woofer in December 2016. They entered into a settlement agreement whereby Woofter agreed to pay $120,000 and assign to Dupass any and all claims Woofter had against his insurance agents, Kansas Insurance, Inc. On December 7, 2018, Dupass filed a petition against Kansas Insurance and several of its agents in Kansas District Court for tort claims and a breach of contract claim for failing to procure the insurance which was part of Woofter's oral agreement with Kansas Insurance, including failure to place his vehicle under the $1,000,000 liability policy. The last policy review Woofter had with Kansas Insurance was in January 2014. The district court dismissed the tort claims, holding they were not assignable. The District Court granted Defendant's motion for judgment on the pleadings, holding the breach of oral contract claim accrued at the time of the breach, not at the time the breach was discovered during the underlying case brought in Arizona. Therefore, the three-year statute of limitations period for breach of unwritten contracts barred Dupass from proceeding. Dupass appealed the decision.

Dupass argued that the agent for Kansas Insurance breached an unwritten contract between Woofter and Kansas Insurance as Woofter had directed them to place his vehicle under his $1,000,000 umbrella policy and not under the $100,000 motor vehicle insurance policy. Dupass further argued the court erred in not finding the limitations period was tolled by the underlying Arizona case, and that the period began to run upon the discovery of the breach, shortly before December 2016. Kansas Insurance argued that the alleged oral contract duty included providing "adequate" coverage, which was accomplished with the motor vehicle policy with a $100,000 policy limit. They also asserted that regardless of the alleged breach, the statute of limitations for the breach of oral contract claim was three years under K.S.A. 60-512, and had expired since the breach occurred at the last policy review in January 2014.

In finding that the claim for breach of a duty to procure insurance could be brought as a breach of unwritten contract claim, the Court of Appeals proceeded with analyzing the statute of limitations issue. K.S.A. 60-512 provides a three-year statute of limitation for causes of action based on unwritten contracts. “As a general rule, a cause of action accrues when the plaintiff could have first filed and prosecuted his [or her] action to a successful conclusion.” Despite Dupass’ arguments that the underlying action in Arizona tolled the claim, the Court found the breach occurred during the last policy review with Woofter in January 2014, and reiterated the principle that an assignee of a claim “stands in the shoes of the assignor,” including assuming their statute of limitations period. Furthermore, the Court denied Dupass’ tolling argument because the breach of contract claim for Woofter did not rely on a preliminary finding in the underlying case in Arizona, (such as a claim against a drafter of a will pending determination of the underlying contested will decision on whether the will was valid or not), and existed at the time of the breach in January 2014. Therefore, the Court of Appeals affirmed the decision granting Kansas Insurance’s motion for judgment on the pleadings, finding the statute of limitations had already run for Dupass’ assigned breach of contract claim.

Dupass v. Kansas Ins., Inc., 491 P.3d 660 (Kan. Ct. App. 2021), *review denied* (Dec. 6, 2021).

Q*. Can the Kansas Court of Appeals remand a case to the Board demanding reimbursement from the Workers’ Compensation Fund that was issued by the Kansas Director of Workers’ Compensation?*

A. No. The Kansas Court of Appeals improperly remanded the case to a jurisdiction that had not previously decided the case.

The issue arose between two insurance carriers to determine which owed benefits to one another for certain time frames. The issue had originally been decided between the carriers by the Director, then the District Court of Kansas. However, the Kansas Court of Appeals remanded the claim to the Kansas Workers Compensation Appeals Board to include the Workers Compensation Fund. Upon the Board determination, Travelers appealed the decision alleging jurisdiction was inappropriate. The Kansas Court of Appeals agreed.

Travelers Casualty Insurance v. Karns, --- P.3d --- (Kan. Ct. App 2021).

Q: When an employee injured his knee descending stairs while at work, was this considered a normal activity of day-to-day living?

A: No. In these circumstances, an employee descending stairs while at work arose out of his employment because his work required he regularly descend stairs while wearing a 30-40 lb. tool belt.

In *Van Horn*, the claimant was working for Blue Sky Satellite and his work duties involved repeatedly climbing ladders and stairs, with a 30-40 lb. toolbelt affixed to his waist while installing satellite dishes and performing service calls. On the date of his injury, he was descending a flight of stairs while wearing his tool belt when he experienced an onset of pain in his knee. There was no fall, twist, or other actual physical incident that clearly

caused the injury. Testimony from the Claimant and the rating physicians revealed no prior knee injuries, but that he likely had degenerative tissue before the injury. The employer denied the claim as an accident arising out of the normal activities of day-to-day living.

K.S.A. 44-508(f)(2)B) provides that an injury does not arise out of and in the course of employment if it was an injury that resulted from the normal activities of day-to-day living. The employer argued walking down stairs was an activity of day-to-day living, with no particular employment character. They cited to several cases for support, including *Johnson v. Johnson County*, where the Court reversed the award of benefits to the Claimant, with prior knee injuries, who injured her knee standing up from her chair while reaching for a file, finding that while the employee was at work, the act of standing up was not "fairly traceable to the employment" in contrast to the hazards which a worker "would have been equally exposed apart from the employment." *Johnson v. Johnson County*, 36 Kan. App. 2d 786, 790, 147 P.3d 1091 (2006). The claimant argued that his employment required him to repeatedly climb ladders and stairs, with a heavy toolbelt affixed to his waist, while installing satellite dishes, and that in his normal nonemployment life he did not climb stairs or ladders at this rate and did not do so with a 30-40 lb. toolbelt strapped to his body.

The Court affirmed the Board's award of benefits finding that claimant had suffered a compensable injury arising out of and in the course of his employment as he satisfied his burden showing it was more probably true than not that he was performing job-related activities which were different from his normal day-to-day activities. Specifically, the Court stated that "[w]hile Van Horn could climb stairs at home, many activities, while done at home or on a daily basis, can also be job-related activities, such is the case here." Thus, they affirmed the Board's finding that ascending stairs with the added weight of the tool belt, during a service call for Blue Sky, was causally connected to claimant's employment, and affirmed the award of benefits accordingly.

Van Horn v. Blue Sky Satellite Services, 491 P.3d 658 (Kan. Ct. App. 2021)

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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. **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.**

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. **Failure to file timely answer results in acceptance of facts in claim, but not legal conclusions.**

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. **20 days to appeal ALJ's award.**
    b. Review of the whole record.
    c. Labor member, commerce member and neutral member.

2. Court of Appeals
    a. **30 days to appeal LIRC decision.**
    b. Review questions of law only.
3. Supreme Court
    a. **30 days to appeal Court of Appeals decision.**
    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 and Temporary Partial 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 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 § 287.067.8)

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. "'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.
    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
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. Employers 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.

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. 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 Claimant meet his burden of proving his accident was the prevailing factor in causing his pulmonary disease when his expert attributed the condition to a workplace injury and two prior exposures?

A: No. The primary work injury in *Mueller* occurred on or about January 13, 2015. On that date, Claimant was working for a staffing agency as a tractor trailer mechanic. While attempting to repair a vehicle he was exposed to exhaust fumes that caused him to vomit several times and lose consciousness twice. He was taken by ambulance to the emergency room but left against the advice of the doctors before testing could be completed.

Claimant had a history of similar injuries while working for other employers. In December of 2011, Claimant suffered an inhalation injury working for Trux Trailer Shop. While welding a tanker containing propane and ammonia anhydrous, Claimant was exposed to metallic fumes that got into his lungs despite the use of a respirator. That injury resulted in breathing difficulties. On August 2, 2012, Claimant suffered another work-related injury while employed at Trux. This time it was related to heat exhaustion, which caused Claimant trouble breathing and focusing.

At trial, Claimant's expert witness, Dr. Hyers, opined "[t]he workplace exposures on or about 12-29-2011, 08-02-2012 and 01-13-2015 are the prevailing factors in causing [Claimant's] disability ...." The *Mueller* Court ruled that this opinion did not establish the January 13, 2015 injury as the prevailing factor causing the medical condition and disability. Rather, it identified it as one of three factors, none of which are specifically identified as the primary factor. Accordingly, benefits were denied.

Mueller v. Peoplease Corporation, 655 S.W.3d 627 (Mo. Ct. App. 2022).

Q: Is Respondent responsible for medical bills incurred after Claimant refused treatment at the Emergency Room, but then followed up with his primary care physician as directed?

A: No. When Claimant was taken to the emergency room following his injury, the ER physician recommended he be admitted so that additional tests could be run. Claimant refused, but agreed to follow up with his primary care doctor so that the tests could be run at a later date. Claimant did then go to his primary care physician and had the testing. Claimant then demanded the medical bills from his primary care physician be satisfied by Respondent.

The Commission denied his request, and held Respondent was only responsible for the medical bills from the ambulance and the emergency room, as those were the only medical services that were specifically authorized by Respondent. The *Mueller* court affirmed the Commission ruling, citing Section 287.140, which states in pertinent part:

> "The employer *shall have the right* to select the licensed treating physician, surgeon, chiropractic physician, or other health care provider ...." Section 287.140.10 (emphasis added). "If the employee desires, he shall have the right to select his own physician, surgeon, or other such requirement *at his own expense.*"

The Court went on to explain that "[i]t is only when the employer fails to provide medical treatment that the employee is free to pick [his] own provider and assess those costs against [his] employer." (citation omitted). In *Mueller*, Respondent had provided authorized treatment in the form of emergency care. Claimant chose to forgo the that authorized treatment and instead treat with his own physician. He was within his rights to do so under the statute, but that treatment was done at his expense.

Mueller v. Peoplease Corporation, 655 S.W.3d 627 (Mo. Ct. App. 2022).

Q*: Did the Claimant sustain a compensable injury by accident in that she suffered 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?*

A: Yes. On June 22, 2018, Claimant was working as a nurse handing out medication to patients when she hurriedly pushed a 100lb medicine cart to allow a patient to walk by using the handrail. Claimant testified that when she pushed the cart she felt a pull in her back. Her back pain progressed throughout the remainder of her shift. By the time she left for the day she was having trouble walking.

In deciding this case, the Court of Appeals analyzed RSMo 287.020.2 which states, "The word "accident" as used in this chapter shall mean 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." Specifically, the Court interpreted the statutory phrase, "producing at the time objective symptoms of an injury." The Court noted this is the first time such language has been interpreted post 2005 when the legislature instructed that earlier case law interpreting the definition of accident should be rejected or abrogated. Therefore, this was a question of first impression.

The Court explained that the "primary rule of statutory interpretation is to ascertain the intent of the legislature from the language used, to give effect to that intent if possible, and to consider the words in their plain and ordinary meaning." The Court consulted Merriam-Webster definitions of the language to determine the statutory phrase an unusual strain "producing at the time objective symptoms of an injury" should be interpreted in the circumstances of this case to mean an unusual strain producing at (i.e., near) the time objective symptoms (i.e., indications perceptible by persons other than Claimant of the existence) of an injury (i.e., violence to the physical structure of Claimant's body)."

In this case, Claimant's difficulty walking would have been perceptible to persons other than Claimant, indicated the existence of violence to the physical structure of Claimant's body, and was produced near the time of the unusual strain. The Commission did not legally err in ruling that Claimant's unusual strain "produced objective symptoms of injury" at the time because the facts found by the Commission – i.e., Claimant "felt a 'pull' in her lower back" and "[s]hortly thereafter [during the same work shift] ... had difficulty walking" – support that ruling.

Harper v. Springfield Rehab & Health Care Ctr./NHC Health, No. SD 37268, 2023 WL 1776279, (Mo. Ct. App. Feb. 6, 2023), reh'g and/or transfer denied (Feb. 24, 2023)

Q: Did the Commission err by not dismissing the claim when the final hearing was not concluded within the timing requirements of Section 287.460 when no contemporaneous objection was made by Employer?

A: **No**. The final hearing in this case was initially scheduled on June 15, 2020. However, while Claimant was undergoing direct examination, he broke down crying, which lead to a recess. His counsel did not believe Claimant was able to move forward and requested that the case be submitted on the medical evidence already admitted. Employer objected, citing the need ty to cross-examine Claimant. Claimant informed his counsel he had recently gotten back on his psychiatric medication and believed he could be stabilized in thirty to sixty days. As a result, his counsel requested a continuance, which was granted without objection.

The hearing resumed on November 9, 2020. Claimant continued his testimony but became upset during cross-examination and a break was taken. Claimant then left the building, as he was upset and did not want to answer any questions. His attorney again requested that the case be submitted on the evidence, and Employer again objected on the basis of wanting to finish cross-examination. The hearing was again continued without any objection.

The hearing resumed again on March 26, 2021. However, Claimant did not appear, and could not be contacted. His attorney requested another continuance, and it was granted without objection. The fourth and final hearing date occurred on May 17, 2021. Claimant completed his testimony, additional exhibits by Employer were received, and all parties rested. Shortly thereafter, an PTD Award was entered on behalf of Claimant.

Employer appealed to the Commission, arguing the claim should have been dismissed because the hearing was not concluded within thirty days as required by Section 287.460 RSMo. Employer argued pursuant to that statute, "only in extraordinary circumstances may the proceedings last longer than ninety days without good cause shown, and the [ALJ] provided no explanation or good cause to deviate from the time requirement."

The Commission upheld the Award. The Court of Appeals then affirmed the decision, noting that Employer's argument was not properly preserved on appeal. "At no point during the hearing, which extended over *four separate dates*, did Employer ever object on the grounds of Section 287.460's timing requirements or to any of the continuances. 'In the absence of an objection, the issue is not properly before us.'" Citing *Goodwin v. Farmers Elevator and Exch.,* 933 S.W.2d 926, 929 (Mo. App. E.D. 1996).

LME, Inc. v. Powell, 661 S.W.3d 370, 372 (Mo. Ct. App. 2023).

Q: Did a stipulation to the date Claimant reached MMI apply to both the accepted back injury and the denied psychological injury?

A: Yes. Employer argued the Commission erred by misstating the parties' agreement regarding Employee's MMI date. Employer claimed stipulation to MMI date was only meant to apply to the accepted physical injury to Claimant's back, not the psychological injury which was denied. The Commission and Court of Appeals both rejected this argument, citing to the following portion of the hearing transcript:

> [EMPLOYEE'S COUNSEL]: Your Honor, could we also – I believe we could stipulate to the MMI date, which was April 12, 2018, when Dr. Bailey released him.
>
> THE COURT: Do all the parties agree to that?
>
> [EMPLOYER'S COUNSEL]: I do, yes.

The *Powell* court pointed out that Employer's counsel made no attempt to distinguish between the physical and psychological injuries during this exchange at trial. Given Employer's failure to delineate the two injuries, the Commission was required to enforce the stipulation that was actually agreed to by the parties. "Stipulations are controlling and conclusive, and the courts are bound to enforce them." *Boyer v. Nat'l Express Co.*, 49 S.W.3d 700, 705 (Mo. App. E.D. 2001) (citation omitted).

LME, Inc. v. Powell, 661 S.W.3d 370, 372 (Mo. Ct. App. 2023).

Q: Did Claimant's earlier compromise settlement of a repetitive trauma injury to the left upper extremity preclude him from recovering for an alleged second repetitive trauma claim involving the left wrist?

A: Yes. Claimant entered into a settlement agreement with his employer for a repetitive trauma claim involving his left upper extremity with date of accident August 26, 2016. Claimant treated with Dr. McNamara for his August 2016 claim. During Dr. McNamara's initial visit, claimant was complaining of left shoulder pain, and numbness and tingling in his left hand. Claimant primarily treated for the left shoulder and claimant underwent surgery on the left shoulder. However, in Dr. McNamara's February 13, 2017 visit he noted that claimant still had carpal tunnel syndrome in the left wrist that might require future attention. After Dr. McNamara released claimant from care, claimant was evaluated by Dr. Stuckmeyer at the request of his attorney who also opined that claimant still had evidence of left carpal tunnel syndrome that was related to claimant's work activities and may require future surgical intervention. On May 2, 2018, the parties entered into a settlement agreement in which the employer agreed to pay the claimant a lump sum representing 12.5% permanent disability to the left upper extremity to settle all issues between the parties and forever close out this claim under the Missouri Workers' Compensation law.

On June 26, 2018, Claimant filed a second claim alleging that on February 13, 2017 claimant suffered an injury to his left wrist due to repetitive trauma. The Employer referred claimant back to Dr. McNamara who opined that claimant's current complaints to his left hand were related to the repetitive work injury that had been the subject of the August 2016 claim. The employer denied further benefits.

The ALJ found that Dr. McNamara's opinion that the prevailing factor for Claimant's left carpal tunnel syndrome was the same as the prevailing factor for his left shoulder injury: the repetitive work activities that gave rise to the August 2016 claim. The ALJ Award noted that Claimant voluntarily elected to settle his August 2016 claim with the knowledge that both Dr. McNamara and Dr. Stuckmeyer had diagnosed him with left carpal tunnel syndrome that might require future surgery, and with the knowledge that the compromise settlement settled "all issues between the parties." The ALJ Award concluded that the August 25, 2016 work injury and resulting August 2016 claim were resolved in the

compromise settlement, so that, absent proof of fraud or mistake, the ALJ was without jurisdiction to reopen the August 2016 claim to amend the compromise settlement to include compensation for injuries to Claimant's left wrist. The Court ultimately found, the Commission did not commit legal error when it concluded that the compromise settlement exhausted its jurisdiction to entertain Claimant's February 2017 claim. Benefits were denied.

Lamy v. Stahl Speciality Co., 649 S.W.3d 330, 339 (Mo. Ct. App. 2022).

Q: What is the standard of review when an appellate court reviews the Commission's denial of benefits?

A: In *Steinbach v. Maxion Wheels,* the claimant alleged a work-related injury to her bilateral upper extremities as the result of her repetitive use of a drill at work. Employer denied the claim, arguing Claimant's injuries were the result of her non-work activities, and that her job did not actually require much repetitive use of her hands.

At hearing, testimony was offered from Claimant, her nephew, and two employer witnesses. Exhibits were also submitted, including medical records and bills, expert medical reports, invoices, a summary of scrap metal purchased by Claimant from her Employer, and receipts showing the sale of some of that scrap metal to a third party.

Following the hearing, the ALJ issued a decision denying compensation, finding Claimant's work activity was not the prevailing factor for her injury, as it was not sufficiently repetitive to cause the injury to her bilateral hands and wrists. The judge specifically found Claimant's testimony about her work activities and her welding activity at home was not credible. It also found Claimant's medical expert not credible, as his opinion was based in part on an inaccurate work history provided by Claimant. Finally, the ALJ found the treating physician's opinions were more credible because they were based on a more accurate description of Claimant's work activities. The Commission affirmed the ALJ's decision denying compensation.

The *Steinbach* court affirmed the Commission decision. In doing so, its analysis focused on the applicable standard of review:

> Under article V, section 18 of the Missouri Constitution, an appellate court reviews the Commission's decision to determine if it is "supported by competent and substantial evidence upon the whole record." *Cosby v. Treasurer of State*, 579 S.W.3d 202, 205 (Mo. banc 2019). The award is reviewed objectively and not in the light most favorable to the award. *Id.* The appellate court reviews issues of law, including the Commission's interpretation and application of the law, *de novo. Id.* It defers, however, to the Commission's findings as to weight and credibility of testimony and are bound by its factual determinations. *Id.* "The Commission, as the finder of fact, is free to believe or disbelieve any evidence." *Id.* (internal quotes and citation omitted). To the extent that the Commission affirmed and adopted the findings and conclusions of the ALJ, the appellate court reviews the ALJ's findings and conclusions for error.

The Court went on to give further explanation of how this standard is applied, stating:

> "The weight afforded a medical expert's opinion is exclusively within the discretion of the Commission." *Mirfasihi v. Honeywell Fed. Mfg. & Tech., LLC*, 620 S.W.3d 658, 666 (Mo. App. W.D. 2021). "Furthermore, where the right to compensation depends on which of two medical theories should be accepted, the issue is peculiarly for the Commission's determination." *Id*. "The Commission is free to believe whatever expert it chooses as long as that expert's opinion is based on substantial and competent evidence. *Comparato v. Lyn Flex W*., 611 S.W.3d 913, 920 (Mo. App. E.D. 2020). (internal quotes, citations, and emphasis omitted). The appellate court will uphold the Commission's decision to accept one of two conflicting medical opinions if such a finding is supported by competent and substantial evidence. *Mirfasihi*, 620 S.W.3d at 666; *Comparato*, 611 S.W.3d at 921. It will not overturn the Commission's determination regarding conflicting medical opinion unless it is against the overwhelming weight of the evidence. *Mirfasihi*, 620 S.W.3d at 666.

The *Steinbach* court found the Commission was within its discretion to find the testimony of Employer's experts more credible than Claimant's experts. Further, the Commission was within its discretion in finding Claimant's testimony not credible. Accordingly, the denial of compensation was supported by sufficient and competent evidence and was not contrary to the overwhelming weight of the evidence.

Steinbach v. Maxion Wheels, Sedalia, LLC, 667 S.W.3d 188 (Mo.App. W.D. 2023).

Q: Does a Commission decision to deny benefits have to be supported by substantial and competent evidence?

A: No. Claimant was employed as a home healthcare worker. On August 15, 2012, Claimant was visiting the home of one of her patients when she hit her head on a canoe that was on top of a car in the patient's driveway, causing her to fall on her back. Claimant experienced pain in her head and back, lightheadedness, and a headache.

After her fall, Claimant received both emergency and follow-up treatment. Dr. James L. Jordan diagnosed Claimant with a cervical strain, thoracic strain, lumbar strain, bilateral arm and forearm strains, and a left hip contusion and strain. He later reevaluated Claimant and determined she had reached MMI for the symptoms of her work injury. Dr. Jordan determined that Claimant's injuries to her shoulder and lower back, both of which occurred weeks after her fall, were unrelated to her work injury.

Claimant filed a workers' compensation claim alleging injuries to her head, neck, back, arms, legs, hips, tailbone, and shoulders, and identified previous injuries to her right foot, left foot, left knee, right hand, and right knee. During the hearing on her claim, the ALJ reviewed Claimant's medical records, the depositions of two doctors and three expert vocational witnesses regarding the degree of Claimant's disability, the need for past medical care, and the need for future medical care.

The ALJ awarded Claimant permanent partial disability benefits and additional temporary total disability benefits but determined Claimant had not met her burden of proof to obtain benefits for past or future medical care, Second Injury Fund liability, or permanent total disability. The Commission confirmed these findings.

On Appeal to the Southern District, the *Kurbursky* court affirmed the decision, stating "[w]hile a workers' compensation award must be supported by competent and substantial evidence, the Commission's decision to *deny* benefits is not an award which requires competent and substantial evidence." *(citations omitted)*. The Court went on to explain that these types of appeals are rarely successful, because they ask the Court "to substitute its views of witness credibility and weight of the evidence for the Commission's own…" The Court is unable to do so, as the applicable standard of review requires it to defer to the Commission's credibility determinations and to the weight it accords evidence.

Kurbursky v. Indep. In-Home Servs., LLC, 648 S.W.3d 894, 900 (Mo. Ct. App. 2022).

Q: Is the work of clearing trees on an annual basis for a farm that is operating a hunting resort for deer season constitute work that is an operation of the usual business of the farm so as to bring the farm within the purview of the Missouri Workers' Compensation Act as a statutory employer?

A: Probably Not. Claimant was a superintendent for Little Dixie Construction Company. The Construction Company contracted with Crown Center Farms, a hunting resort, to cut down trees to clear some land. While claimant was cutting down trees at the hunting resort he was struck by a tree and sustained significant injuries. Claimant brought a workers' compensation suit against his direct employer, Little Dixie. Claimant also pursued a civil suit against Crown Center Farms for negligence. Crown Center Farms asserted they were claimant's statutory employer and therefore claimant's exclusive remedy was via the workers' compensation act. The district court granted summary judgment to Crown Center Farms on this issue. The Court of Appeals reversed and remanded the case to the District Court for further proceedings.

The Court of Appeals provided a thorough analysis of when an entity will be considered a "statutory employer." The Court stated, "a person or entity is a statutory employer of the statutory employee if: (1) the work is performed under a contract; (2) the injury occurs on or about the premises of the purported statutory employer; and (3) the work is an operation of the usual business of the statutory employer."

The Court cited to the Supreme Court's decision in *Bass* as authority for determining what constitutes "usual business" within the meaning of the statute. The Court explained "usual business" means, "those activities (1) that are routinely done (2) on a regular and frequent schedule (3) contemplated in the agreement between the independent contractor and the statutory employer to be repeated over a relatively short span of time (4) the performance of which would require the statutory employer to hire permanent employees absent the agreement." *Bass v. National Super Markets, Inc.*, 911 S.W.2d 617 (Mo. banc 1995).

In so defining "usual business," the *Bass* Court specifically sought to exclude from its definition "specialized or episodic work that is essential to the employer but not within the employer's usual business as performed by its employees." "Whether a particular sort of work is within a party's usual course of business is a fact-driven inquiry; there is no 'litmus paper' test."

In this case, the Court found the summary judgment record failed to establish with any precision how frequently or regularly trees were cut down at Big Buck by Crown Center

Farms' employees. Moreover, and most significantly, there is no indication from the summary judgment record that Crown Center Farms would have been required to hire permanent employees to cut down trees at Big Buck in the absence of an agreement between Crown Center Farms and Little Dixie Construction. From the record, there were no facts supporting a conclusion that the performance of a roughly annual task at an area within a recreational hunting area would require the hiring of permanent employees in the absence of the agreement between Crown Center Farms and Little Dixie Construction. Thus, under the *Bass* test, the summary judgment record failed to establish that the clearing of trees at Big Buck was within the usual business of Crown Center Farms to support a finding of Crown Center Farms statutory employer status. As such the Court found the trial court erred in granting summary judgement to Crown Center Farms.

Brooks v. Laurie, 660 S.W.3d 394, 400 (Mo. Ct. App. 2022), reh'g and/or transfer denied (Dec. 20, 2022), transfer denied (Mar. 7, 2023).

Q: Is it sufficient to show that a preexisting disability affected the primary injury to render it a qualifying pre-existing disability for purposes of determining Fund liability?

A: No. Claimant had multiple preexisting issues, including cardiac issues and a congenital condition where his ribs fuse with his spine resulting in constant pain and limited range of motion. He also dealt with right shoulder pain for years which he attributed to his work duties of cranking jacks to adjust the heights of semi-trailers. In 2016 he was diagnosed with bursitis of the shoulder.

In October of 2017, Claimant slipped while exiting a truck and caught himself with his right arm. He immediately felt a pop in the right shoulder and was later diagnosed with a RTC and labrum tear. After settling the 2017 workers' compensation claim with his employer, Claimant filed suit against the Fund alleging PTD as a result of the combination of his preexisting disabilities and the disability from his 2017 injury.

At trial, the ALJ concluded Claimant failed to demonstrate he suffered from a "qualifying" preexisting disability under section 287.220.3. Claimant appealed to the Commission, which agreed with the ALJ's determination that Claimant failed to show his preexisting disabilities "directly and significantly aggravated or accelerated" his primary injury pursuant to Section 287.220.3(2)(a)a(iii).

The Court of Appeals affirmed the decision of the Commission, relying on its factual findings that the expert medical evidence was vague and failed to definitively establish as a factual matter that the preexisting disabilities "significantly and directly aggravated his primary injury." The evidence was sufficient to show the conditions had some worsening effect on the primary injury, but did not rise to the level of "**significant and direct**" aggravation or acceleration.

Swafford v. Treasurer of Missouri, 659 S.W.3d 580 (Mo. 2023).

Q: Did the Commission abuse its discretion by not allowing additional discovery and evidence upon remand by the Court of Appeals?

A: No. This claim involved an October 2015 workplace accident in which the claimant fell off a ladder injuring his wrist, kidneys, and lower back. Claimant alleged a permanent total

disability claim against the Fund alleging his pre-existing disabilities which included multiple hernias, and factor V ledien mutation with anticoagulation, combined with his primary injury rendered him PTD pursuant to 287.220.2 (old Fund PTD standard). A hearing was held before the ALJ in June 2018 in which the judge denied Fund benefits. Claimant appealed to the Commission, which reversed the ALJ's decision and awarded claimant benefits per 287.220.2 (old Fund PTD standard). The Fund appealed to the Court of Appeals. While this case was pending before the Court of Appeals, the Supreme Court handed down *Cosby* which held that 287.220.3 (new Fund PTD standard) applies when any injury occurred after January 1, 2014. Therefore, in this case, the Court of Appeals ruled that under *Cosby* claimant was required to meet the standards set forth in 287.220.3 (new Fund PTD standard). Accordingly, it reversed the Commission's award and remanded the case, instructing the Commission to determine whether clamant was entitled to Fund liability under 287.220.3 (New Fund PTD standard). On remand, Claimant filed a motion to conduct additional discovery, submit additional evidence, and submit supplemental briefs. He contended he had "newly discovered evidence which with reasonable diligence could not have been produced at the hearing before the [ALJ]." 8 C.S.R. 20-3.030(2)(A). The Commission overruled Claimant's motion, reasoning that allowing additional evidence would be contrary to the court of appeals' mandate.

The Court explained, "There are two types of remands: (1) a general remand that does not provide specific direction and leaves all issues open to consideration in the new trial; and (2) a remand with directions that requires the trial court to enter a judgment in conformity with the mandate." *Lemasters v. State*, 598 S.W.3d 603, 606 (Mo. banc 2020). When the mandate contains specific instructions for a circuit court, the circuit court has no authority to deviate from those instructions. *Id.* Here, the Court of Appeals did not include any language in its opinion or remand mandate instructing the Commission to reopen the case or hear additional evidence. Thus, claimant's argument fails.

Second, Claimant contended that he met the requirement of newly discovered evidence under 8 C.S.R.20-3.030(2)(A), entitling him to additional discovery and submission of additional evidence. Claimant contends that at the time of his discovery he was under the impression that pursuant to *Gattenby* 287.220.2 (old Fund PTD standard) was applicable and that even with reasonable diligence he would not have known to adduce evidence from his experts relevant to 287.220.3 (new Fund PTD standard) because he did not have notice that section applied. The Court disagreed with Claimant's argument noting that both 287.220.2 (old Fund PTD standard) and 287.220.3 (new Fund PTD standard) were in effect at the time of claimant's workplace injury and the new standard governed his claim by the plain language of the statute. Furthermore, while the Court of Appeals interpreted the statute in *Gattenby*, the Supreme Court had yet to weigh in on the issue and therefore claimant should have adduced evidence from his experts relative to both statutory standards.

Dubuc v. Treasurer of State, 659 S.W.3d 596, 600 (Mo. 2023).

Q: If a pre-existing injury was merely "self-reported" does that meet the standard of a "medically documented" preexisting injury to spark Second Injury Fund liability?

A: No. An employee is entitled to Fund benefits under section 287.220.3(2)(a)a(iii) if the employee can show he was rendered permanently and totally disabled by a "medically

documented" preexisting disability that "directly and significantly aggravates or accelerates" his primary workplace injury. The Court looked to the plain language of the statute to interpret what is meant by "medically documented." The Court explained, "Medically documented" is not defined in the workers' compensation statutes. *Webster's Third New International Dictionary* defines "documented" as "to provide with factual or substantial support for statements made or a hypothesis proposed" or "to equip with exact references to authoritative supporting information." *Webster's Third New International Dictionary of the English Language* 666 (3d ed. 1993). Accordingly, the "documented" requirement should be interpreted to mean that something more than unsupported statements of a preexisting disability are necessary. Rather, a claimant must provide authoritative support of a preexisting disability. Further, however, not only must the preexisting disabilities be documented, they must be *medically* documented. "Medical" is defined as "of, relating to, or concerned with physicians or with the practice of medicine." *Id.* at 1402. Consequently, the provided authoritative support for a preexisting disability must be authoritative *in the medical field."*

In this case, claimant relied on self reported history that he communicated to doctors for support of his hernias. The Court explained that claimant's own statements about his hernias, albeit recorded by doctors in medical records, do not conclusively support that any doctor has medically documented claimant having hernias. Therefore, Claimant's self-reported history of his hernias was insufficient to establish a "medically documented" preexisting disability under section 287.220.3.

Dubuc v. Treasurer of State, 659 S.W.3d 596, 603 (Mo. 2023).

Q: Does expert testimony that states the combination of claimant's pre-existing injuries as well as the primary injury rendered the claimant permanently and total disabled constitute evidence that claimant's pre-existing injury "directly and significantly aggravated or accelerated" the primary injury to spark Fund liability per 287.220.3(20(a)a(iii)?

A: No. Section 287.220.3(2)(a)a(iii) requires an employee to show permanent and total disability from a qualifying preexisting disability that "*directly and significantly aggravates or accelerates*" his primary workplace injury. The Court explained that "under the plain meaning of the statute, the employee must show "the impact of the preexisting disabilities on the primary injury [is] more than incidental; they must clearly exacerbate the primary injury in a meaningful way." *Swafford*, No. SC99563, 659 S.W.3d at 584. Testimony that a "combination" of injuries renders an employee permanently and totally disabled does not establish the particular impact of claimant's pre-existing factor V leiden mutation or his prior reported hernias on his primary injury. *Id.* at 7. Even assuming some impact, no evidence shows that claimant's factor V leiden mutation or his hernias impacted his primary injury in a meaningful way. Therefore, the Court found that claimant failed to prove his pre-existing injuries met the requirement of RSMo 287.220.3 to spark Second Injury Fund liability.

Dubuc v. Treasurer of State, 659 S.W.3d 596, 605 (Mo. 2023).

Q: Can disability to Claimant's bilateral knees and back from a prior workers' compensation accident be combined to satisfy the fifty-week PPD minimum for qualifying preexisting disability?

A: No. Claimant was a 62-year-old man that had worked primarily as a diesel mechanic. He suffered three significant work-related injuries during his career.

In 1984, while working on an exhaust, Claimant tore ligaments, tendons and nerves in his left hand which resulted in extensive reconstructive surgery. As a result, he has limited mobility in his left hand. The 1984 claim settled for 32.5 percent of his left hand at the 175-week level of the wrist, which is 56.875 weeks of disability.

In 2001, Claimant fell from scaffolding while working on a trailer roof resulting in injuries to his back and both of his knees. He had surgery on both knees and chiropractic massage on his back. His doctor determined he had 35% permanent partial disability of the right leg, 35% permanent partial disability of the left leg, and 7.5% permanent partial disability of the body as a whole due to his back, a lumbar condition. Employer's doctor determined Adams to have 5% permanent partial disability of the right leg, 3% permanent partial disability of the left leg, and 2% permanent partial disability of the body as a whole due to his lumbar condition, or 5% body as a whole for all three disabilities.

He settled the 2001 claim based upon an approximate disability of 15% of the body as a whole. The stipulation indicated that was for disability to the "bilateral knees and the low back (400-week level)." That is equivalent to 60 weeks of disability. However, the Compromise Settlement does not provide a breakdown of weeks of disability attributed to the low back or each knee.

Claimant's third and final injury occurred on September 17, 2015. He was working on semi-trailer brakes when his right hand was crushed and pinned between a jack handle and the bottom of the trailer. Surgery was performed on his right shoulder and bicep. Thereafter, he filed a workers' compensation claim against Employer for PPD and a claim against the Fund for permanent total disability ("PTD").

At Hearing for the third injury, the Administrative Law Judge ("ALJ") issued an Award concluding Claimant was permanently and totally disabled as a result of the primary injury (the 2015 claim) together with his prior disabilities from the 1984 claim and the 2001 claim.

The Fund appealed the ALJ's Award to the Commission, asserting the ALJ erred because the ALJ included the disabilities which resulted from the 2001 claim in his determination, but those disabilities do not qualify under Section 287.220(3)(a). The Fund claimed the 2001 claim resulted in disabilities to two specific body parts, the knees and the back, which are separate disabilities that do not separately meet the 50-week threshold. Additionally, the Fund claimed the ALJ erroneously relied on *Treasurer v. Parker*, No. WD83030, 2020 WL 3966851 (Mo. App. W.D. July 14, 2020), to circumvent section 287.220(3)(a), which was later vacated by the Supreme Court in *Treasurer of State v. Parker*, 622 S.W.3d 178 (Mo. banc 2021). The Commission reversed the ALJ's Award finding the Fund had no liability.

The Court of Appeals affirmed the Commission decision, relying on the Supreme Court's decision in *Treasurer of State v. Parker,* 622 S.W.3d 178 (Mo. 2021). In *Parker*,[1] the Court

held the statute explicitly requires an employee to demonstrate PTD solely by a combination of disability related to the employee's primary injury and preexisting disabilities that qualify under that statute. The *Parker* court expressly rejected the notion that additional, non-qualifying preexisting disabilities may be considered in assessing Fund liability.

The *Adams* court went on to explain it was bound by the Commission's factual determinations. Specifically, the finding that the 2001 injury included two disabilities that were clearly differentiable and neither met the 50-week threshold. Accordingly, neither of those disabilities met the standard of preexisting disability as defined by Section 287.220.3(2). As a result, neither could be considered to support a claim against the Fund for PTD. This was fatal to Claimant's case against the Fund because no expert testified he would be PTD in the absence of both disabilities attributable to the 2001 injury when considered together. In other words, the Commission found "[b]ecause non-qualifying preexisting disabilities contributed to employee's PTD, *Parker* compels us to conclude that the [Fund] has no liability in this case."

Adams v. Treasurer of State, 662 S.W.3d 8, 17 (Mo. Ct. App. 2022), reh'g and/or transfer denied (Nov. 22, 2022), transfer denied (Apr. 4, 2023).

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ILLINOIS WORKERS' COMPENSATION

I. Jurisdiction - Illinois jurisdiction is appropriate when:

A. The petitioner is injured in Illinois, even if the contract for hire is made outside ofIllinois;

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; or

C. 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 be 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. Three types of risks include: (1) an employment risk; (2) a personal risk; or a (3) neutral risk
    - *McAllister* Supreme Court decision impacts what is considered an "employment risk"
3. 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 afterthe 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 arethose 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 may choose thehealth 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 theprogram 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 subjectto 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 in the modified job.
2. Applicable when the employee is working light duty on a part or full-timebasis.

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—beginning 01/01/22, the Illinois minimum wage is higher ($12/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, neck, and head 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 repetitive trauma carpal tunnel cases tothe 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 (or acute 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 abovethe 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 disabilityfor a specific body part, not both.

K. **Death**

1. Maximum that can be received can't exceed $500,000 or 25 years of benefits, whichever is greater.
2. Burial costs up to $8,000.

L. **Permanent Total Disability**

1. Only arises when the petitioner is completely disabled which means thepetitioner 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 iscapped 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 or a self-direct job search.
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 inwhich 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 orbusiness after the accident.
4. The 2011 Amendment to Section 8(d)(1) now provides that for accidents onor 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 ofimpairment 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 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 5 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 pre-try case.
    - If the parties have already pre-tried the case, the parties will select a time to try the case.
4. 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.
5. A pretrial conference (Request for Hearing) 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.
    - Arbitrators require that a case be pre-tried prior to setting any case for trial.
6. 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.

7. 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 automatically.
    - 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 underthe 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 before 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 on or after 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 amountof 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 diseasesthat do not arise out of an identifiable accident or occurrence but notrepetitive 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 resultof 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—Landmarkcase: *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 physicalwhen 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 subsequentlyloses 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 anarbitrator'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 intervalsuntil the case has been on file for three years, at which time it is considered above the "redline."
    - Cases above the "redline" are set for a pre-trial or dismissed for want of prosecution, unless the parties request a continuance for "good cause" prior to the docketcall 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.
3. Three arbitrators are assigned to a particular zone and they rotate betweenthe 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.
    - Parties must 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 theCommission.
2. The petitioner and insurer/employer will execute a Lump Sum Petition and Order and Affidavit(s) reflecting the parties' agreement. Once executed, the insurer/employer will submit the documents to the Commission and the case will be assigned a Case Number, arbitrator, and docket location.
3. Once scheduled, the parties can appear virtually for settlement contract approval. The parties can also appear in person at the assigned arbitrator's docket location, if needed.

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 amountof 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 ofTTD 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.
4. 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.
5. 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 thebill the basis for nonpayment or underpayment.

    - The bills must be provided to the insurer/employer by the petitioner with the appropriate HCFA or UB-04 form (and accompanying medical records) 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.

6. 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 costsagainst 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 promptlyand 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 denyingbenefits 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 themost recent (*e.g.,* Sixth Edition) AMA Guidelines.
        ii. An impairment rating will be one of several factorsconsidered 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 toappear 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 priorwork injuries to scheduled body parts but <u>not</u> for unscheduled (e.g., body as 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

- Parties are required 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 fewdays or week afterwards.

1. Allows the parties to argue their positions and obtain the arbitrator's opinionabout issues, including causation, nature and extent, additional medical treatment, etc.
2. 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 onhis 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 of the 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 Habitat for Humanity that fell within his restrictions, but the petitioner refused to attend because Habitat for Humanity was not his employer.
    - The Commission determined the petitioner was not entitled to TTD afterhis refusal to attend the transitional, light-duty work assignment becausehe was still to be paid by the employer, remained under the same 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 terminateTTD benefits when they can offer transitional, light-duty work within the petitioner’s restrictions at another employer so long as remain an employeeof 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 arbitratorand/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 a wage differential.
    - The insurer/employer is required to provide weekly payments totaling2/3of 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, butnow 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 employablebut 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 showingavailability of suitable work.

E. Vocational Rehabilitation

1. When there is no dispute that the petitioner is unable to return to his priorjob because of the work injury or the period of total incapacity exceeds 120continuous 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 findsuitable employment; the petitioner has sufficient skills to obtain employment without further training or education or has undergone similarrehabilitation 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 their restrictions.
    - Maintenance is similar to TTD benefits, but is a component of vocational 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 undergoa 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: When an employee slips and falls on ice or snow in an employer-controlled/provided parking area, does the accident arise out of and in the course of employment?

A: Most likely, because the "parking lot exception" is applicable in circumstances where there is some hazardous condition in a parking lot that the employer owned or asserted sufficient control over, regardless if the general public can park in that location.

In *W. Springs Police Dep't v. Illinois Workers' Comp. Comm'n*, petitioner appealed from the order of the circuit court reversing a decision to award her benefits under the Illinois Workers' Compensation Act. The appellate court reversed the decision and upheld the Commission's decision. Petitioner sustained injuries to her wrist and arm while employed as a crossing guard for the Village of Western Springs Police Department. The angled parking space in which she parked was not reserved for Village employees. The space was for commuter train parking, limited to 4 hours in duration, and available for use by the general public. But the Village granted her and several other Village employees the privilege of parking in the angled parking spaces in excess of the 4-hour parking limitation applicable to members of the general public. Petitioner was also required to give the Village her license plate number so that the police officers would know that it was her car and not issue a citation for parking in excess of the 4-hour parking limitation.

The Appellate Court found the Commission correctly determined that the preponderance of the evidence demonstrated that the Village owned the parking premises where the accident occurred, exercised control or dominion of the area, and although there is no evidence that the Village required the petitioner to park there, they did confer different parking rules so that Village employees could use that parking space. Based on the Village having granted the claimant and other Village employees the privilege of parking in the parking space where the claimant slipped and fell in excess of the 4-hour parking limitation applicable to members of the general public, the court concluded that the Commission's finding that the claimant fell in an employer provided parking space is not against the manifest weight of the evidence. When, an employee slips and falls on ice or snow in an employer provided parking area, the resulting injury arises out of and in in the course of her employment.

W. Springs Police Dep't v. Illinois Workers' Comp. Comm'n, 2023 IL App (1st) 211574WC.

Q: Is an injured worker entitled to a wage-differential award under the Illinois Workers' Compensation Act if the injury does not reduce earning capacity?

A: No, the purpose of a wage-differential award is to compensate an injured claimant for his reduced earning capacity, and if the injury does not reduce his earning capacity, he is not entitled to such compensation.

In *Haepp v. Illinois Workers' Compensation Commission*, claimant was awarded benefits for four separate injuries he sustained while working for respondent, the City of Chicago. Following the hearing, the arbitrator found that claimant sustained compensable injuries on each of the alleged dates and awarded him temporary total disability (TTD) benefits as well as reasonable and necessary medical expenses. On appeal the Commission declined to award wage-differential benefits and penalties and fees. To prove entitlement to a wage-differential award under the Illinois Workers' Compensation Act, a claimant must show that (1) he is partially incapacitated from pursuing his usual and customary line of employment and (2) there is a difference between the average amount which he would be able to earn in full performance of his duties in occupation in which he was engaged at time of accident and the average amount which he is earning or is able to earn in some suitable employment or business after accident. The purpose of a wage-differential award is 'to compensate an injured claimant for his reduced earning capacity, and if the injury does not reduce his earning capacity, he is not entitled to such compensation.

Claimant proved he was partially incapacitated from pursuing the duties of his usual and customary line of employment but failed to prove he suffered an impairment of earning capacity. The Commission did not preclude claimant from presenting evidence of his current earning capacity and did not focus exclusively on a comparison of claimant's pre- and post-injury income in finding that claimant failed to prove an impairment in earning capacity. The Commission's decision considered claimant's post-injury income, along with evidence pertaining to other factors, in reaching its decision. The Commission agreed with the arbitrator's determination that claimant failed to prove an impairment of earning capacity, finding the present case distinguishable from *Jackson Park Hospital*. In doing so, the Commission first considered the nature of claimant's post-injury employment. The Commission found that claimant had permanent work restrictions of no kneeling or squatting following his knee injury but continued working for respondent as a union carpenter earning the same wage as the other union carpenters.

Thus, respondent accommodated his restrictions by assigning him work that required no kneeling or squatting. Claimant competently performed such tasks on a consistent basis when he returned to work for respondent. Claimant testified that he worked for respondent on an accommodated basis at the time of the hearing and that he performed a wide range of assignments within his restrictions, including replacing doors, putting on door closers and hinges, working on locks and ceilings, patching holes in drywall, and constructing various structures. Therefore, the evidence showed that respondent was neither paying claimant to perform job duties he was unqualified to perform nor paying him a wage above what is normally paid for such services.

Haepp v. Illinois Workers' Comp. Comm'n, 2022 IL App (1st) 210634WC.

Q: Is an employee's injury, sustained while walking across the floor at an employer's place of business, subject to the employment risk analysis?

A: No. By itself, the act of walking across a floor at the employer's place of business does not establish a risk greater than that faced by the general public and is therefore a neutral risk.

In *Buckley v. Illinois Workers' Comp. Comm'n*, the claimant arrived at the fire station and used the treadmill before his shift began; after using the treadmill, his knee felt stiff. When the claimant's shift began, he responded to a call involving a vehicle accident.

After he finished assisting medical personnel at the scene, the claimant guided the engine driver to back up the firetruck, so it no longer blocked traffic. He then ran around the front of the engine and jumped into the engine to hurry up and get out of the way of traffic. This required him to perform a right-hand pivot on the driver's side corner and then another right-hand pivot on officer side of the engine. He then grabbed the door latch and jumped up onto the step for the seat and got into the vehicle in a fluid motion. While sitting in that cramped space, the claimant's knees were bent at a 90-degree angle, and he was unable to extend his legs or move his legs and feet. He felt uncomfortable, but he testified that he did not initially feel any pain when he exited the engine at the scene of the vehicle accident or when he jumped into the engine as the firetruck left the scene.

He did not seek any treatment for any injury at the scene of the vehicle accident or immediately after leaving the scene. When he returned to the station, the claimant did not report that he had sustained an injury at the scene of the vehicle accident. After getting out of the engine and attending a meeting, his discomfort was getting worse at that time, and he was unable to straighten his leg. However, after leaving a training session, he tried to extend his knee. He then heard a popping sound, his knee gave way, and he fell to the ground.

The Deputy Chief testified that, while he was treating the claimant in his office, the claimant never indicated that he had had any type of incident at the fire run that morning, and he never reported a work injury after the fire run. Dr. Alpert subsequently opined that: (1) the claimant had preexisting right knee osteoarthritis and a degenerative medial meniscal tear; and (2) the claimant's condition was not causally related to a work-related accident. Dr. Alpert noted that the claimant had been complaining of pain and stiffness in the knee prior to the accident, and he did not have any kind of traumatic twisting injury to the knee. The claimant's running at work temporarily exacerbated the preexisting arthritic changes in his knee.

The Commission employed a neutral risk analysis after determining that the claimant's injury had no particular employment characteristics. Specifically, the Commission found that the evidence failed to show that the claimant sustained any kind of specific accident or injury while responding to the vehicle accident or while returning to the firehouse while seated in the cramped quarters of the fire engine.

Based on its review of the medical records, including the statements the claimant had made to various treaters, therapists, and his employer, and upon its review of the claimant's testimony at arbitration, the Commission found that the claimant's statements regarding the circumstances and mechanics of his injury were inconsistent, and therefore not credible.

Buckley v. Illinois Workers' Comp. Comm'n, 2022 IL App (2d) 210055WC-U.

Q: Must there be a causal connection between employee's pre-existing spinal condition of radiculopathy and the work-related accident to receive payment of past and future medical expenses?

A: Yes, here the doctor's records stated that the petitioner's radiculopathy had nothing to do with his CRPS and the causation of the radiculopathy was difficult to assign.

In *Montgomery v. Illinois Workers' Compensation Commission*, petitioner sought payment from respondent, Caterpillar Logistics Services, Inc., for past and future medical expenses to treat a workplace injury he sustained while employed by respondent. Petitioner was driving a forklift for respondent when his forklift was bumped by another forklift. He had hold of the accelerator with his right hand and was thrown forward in the cab, resulting in a jarring or jamming of his right arm. The Appellate Court held that the Commission exceeded its statutory authority by commanding designation of central treating physician, but evidence was sufficient to support the conclusion that claimant failed to prove causal connection between his radiculopathy and his work-related accident.

The Workers' Compensation Commission exceeded its statutory authority under the Workers' Compensation Act, in proceedings on claimant's petition for payment of past and future medical expenses to treat a workplace injury, by commanding the designation of a central treating physician other than claimant's physician, and by requiring that such physician be either from particular clinic or with an accredited, university-based medical center in particular geographic areas. No provision of the Act empowered the Commission to attach conditions to its finding of whether future medical care was necessary and reasonable.

Furthermore, evidence was sufficient to support the conclusion that workers' compensation petitioner failed to prove causal connection between his radiculopathy and his work-related accident. In proceedings on claimant's petition for payment of past and future medical expenses, the physician who performed independent medical examination (IME) wrote in his report that claimant's radiculopathy had nothing to do with his chronic regional pain syndrome (CRPS), and that causation of his radiculopathy was difficult to assign.

Montgomery v. Illinois Workers' Comp. Comm'n, 2022 IL App (3d) 210604WC.

Q: Are findings of a causal connection between the accident and claimant's current condition of ill-being credible because the finding is based on claimant's statements that she/he was injured?

A: Yes, there were several opinions of physicians that supported the causal connection. It is for the Commission to judge the credibility of the medical evidence, weigh that evidence, and draw inferences from the evidence.

In *McDonald's v. Illinois Workers' Compensation Commission*, claimant went to the refrigerator to obtain a box of meat. Claimant grabbed a box from the top shelf, which was above the height of claimant's eyes and forehead. As she retrieved the box, she placed it on her left shoulder and the box began to fall, twisting her lower back. As the box was falling, claimant tried to stop it with her right hand and felt pain in her right shoulder. She took the meat to the kitchen and told two supervisors what occurred.

McDonald's own medical expert, Dr. Phillips, opined claimant's shoulder and arm injuries were caused by her work accident. McDonald's attempted to discredit its own expert because his opinion was based on claimant's description of an accident. Claimant reported that she did not experience back or shoulder pain prior to the accident. Dr. Jain opined claimant's shoulder and back injuries were directly related to the accident based on examination and imaging. Dr. Vargas also thought the back and shoulder conditions were related to the work injury, based on his physical examination, the medical records, and imaging. Dr. Vargas recognized claimant had degenerative back conditions, but noted her back was asymptotic prior to the accident and symptomatic afterward. The Appellate Court held a rational trier of fact could agree with this conclusion. Therefore, the Commission's finding of a causal connection between the accident claimant suffered at work, and the current condition of claimant's shoulder and back ill-being is not against the manifest weight of the evidence.

McDonald's v. Illinois Workers' Comp. Comm'n, 2022 IL App (1st) 210928WC.

Q: Does an employer/employee relationship exist if the employer has control over where and when the employer does his/her work?

A: Yes, if the employer exercises significant control over where and when the employee works and the employee is required to seek approval.

Claimant, Kenneth Wright, was a staff photographer for the Final Call newspaper ("FCN"), where he arrived at FCN's newspaper office, signed in, and began searching for news events to cover. He found a story about the fire deaths of three infants and because he did not own a vehicle, he took public transportation to the scene. After boarding the southbound bus, he took three or four steps when the force of the bus moving caused him to fall. His left leg bent at the knee, and he hit his back and left arm on the floor of the bus. Claimant notified FCN's editor because he was unable to walk. Dr. Robert Muhammad referred him to Dr. Kermit Muhammad at Oak Orthopedics.

On an intake form at Oak Orthopedics, a member of the registration staff recorded that the claimant was to be seen for left knee complaint sustained when he slipped going to

his seat on a bus on January 7, 2009. The form contains a question: “Is this a work-related injury?”; followed by the word “No.” The claimant was seen that day by Dr. Kermit Muhammad who noted a history of the claimant having “sustained an injury during the course of his work duties when he slipped on a CTA bus in Chicago during January of this year.”

Dr. Kermit Muhammad estimated both that the claimant might be able to return to work in 6 to 9 months, depending upon his progress and that the claimant's entire recovery period was expected to be at least 12 to 18 months if there were no complications. On March 23, 2009, Dr. Kermit Muhammad executed a work status report relating to the claimant which stated: “No work until further notice.” On April 7, 2009, Dr. Kermit Muhammad issued a work status report, stating that the claimant could begin working from home on the internet from 11:00 a.m. until 5:00 p.m. with his leg elevated.

FCN continued to pay the claimant through September 2, 2009, but made no further payments thereafter. In a letter dated September 3, 2009, the law firm representing FCN sent a letter to the claimant via his attorney, stating that FCN was terminating all payments to him because, although he was “once employed” by FCN as a photographer, he had not been “actively working” for several months. However, the claimant testified that FCN never offered him light duty work.

FCN argued the claimant shared an employer/independent contractor relationship, noting the claimant was free to take pictures for other newspapers, it never attempted to stop the claimant from doing so, and it allowed the claimant to use its cameras when freelancing for other newspapers. FCN contended that the claimant controlled his own actions as evidenced by his ability to select news events to cover, his freelance photography for other papers, and the fact that the claimant was not reimbursed for travel when he was taking photographs for FCN.

However, the Appellate Court upheld the Commission’s decision that the claimant sustained injuries on January 7, 2009, that arose out of and in the course of his employment with FCN and a causal connection exists between the claimant's current condition of ill-being and his January 7, 2009, accident. FCN was subject to the provisions of the Act, an employer/employee relationship existed between FCN and the claimant, and the claimant gave FCN timely notice of his accident.

The evidence established that FCN exercised control over the claimant's work. It controlled his choice of subjects to photograph for it, and he was required to seek approval from the editor or his supervisor before pursuing his own selection of stories to pursue. FCN controlled where the claimant did his work and when, noting that the claimant testified that he was required to be in FCN's office when he was not out on assignment, and when he was out on an assignment, he was required check in by phone.

Final Call, Inc. v. Illinois Workers' Comp. Comm'n, 2022 IL App (1st) 211137WC-U.

Q: Does the exception of the traveling employee apply if the travel is not an essential element of employment?

A: No. If there is no evidence such that employer reimbursed employee for travel expenses, nor did it assist in making travel arrangements, then the travel is not an essential element of employment.

Claimant, Brooke Hoots, filed a claim for benefits under the Illinois Workers' Compensation against her employer, Dollar General, seeking benefits for an injury to her left foot and ankle that arose out of and in the course of her employment. Claimant parked her vehicle in a parking lot near employer's store in South Jacksonville, Illinois. As she was walking into the store to attend a mandatory employee training, she slipped on black ice, fell, and injured herself in the parking lot.

The Commission and Appellate Court concluded that the parking lot where claimant fell was open equally to both the general public and employer's employees, thus she was not at a greater risk than the general public when she fell. The arbitrator noted that claimant failed to offer credible evidence to support a finding that employer either owned or maintained the parking lot; she did not present evidence that she entered or exited the store any more frequently each day of training than any customer who came into the store; and claimant admitted that employer did not direct its employees where to park.

Furthermore, there was no damage or defect noted in the parking lot, given claimant fell on black ice. The arbitrator also determined that there was no evidence that claimant's folder containing training information that she carried impacted her fall.

Claimant also failed to provide evidence that she was a traveling employee. Claimant did not provide evidence that she was paid for her travel time and expenses. The parking lot was neither owned nor maintained by employer, claimant was not directed where to park when she attended training, there was no evidence that the parking lot was a route required by employer, and the parking lot was open to the general public, including customers of nearby businesses and thus not compensable under the Workers' Compensation Act.

Hoots v. Illinois Workers' Comp. Comm'n, 2022 IL App (4th) 220041WC-U.

Q: Is the determination of the existence of an employer-employee relationship based on a strict application of specified factors?

A: No, the determination of the existence of the employee-employer relationship is based on the totality of the circumstances, and not a strict application of any specified factors.

Factors that have been held to determine the existence of an employment relationship include whether the employer may control the manner in which the person performs the work, whether the employer dictates the person's schedule, whether the employer pays the person hourly, whether the employer withholds income and social security taxes from

the person's compensation, whether the employer may discharge the person at will, and whether the employer supplies the person with materials and equipment.

In *Tile Roofs, Inc. v. Illinois Workers' Comp. Comm'n*, the Commission found the substance of claimant's relationship to respondent never changed after claimant retired from the union or after claimant formed an LLC. In this case, the Commission considered that (1) claimant continued to supervise crews comprised of Mortenson employees, (2) claimant still ordered equipment and materials for the roofing projects either for respondent or Mortenson, (3) Mortenson continued to furnish most of claimant's tools, (4) respondent or Mortenson still provided a company vehicle to claimant and paid for its fuel, (5) Mortenson still paid for claimant's hotels when he stayed out of town for projects, and (6) Mortenson provided the training claimant needed for the zinc roofing project at issue. Each of these, and the totality of them, supported the Commission's determination claimant was respondent's employee.

Tile Roofs, Inc. v. Illinois Workers' Comp. Comm'n, 2022 IL App (1st) 210819WC-U.

Q: *Do the exclusive remedy provisions of the Illinois Workers' Compensation Act ("the Act") bar a worker from bringing an asbestos injury lawsuit against their employer?*

A: No, because a valid contract of service between the employer and employee must exist, and the agreement at issue was illegal, so no valid contract was formed.

In *Daniels*, the plaintiff was a temporary worker hired by ABC. ABC was hired by SIPA as an independent contractor to remove asbestos scraps from its facility. ABC was not licensed to remove asbestos. Daniels was directed by ABC to remove the debris. He was not given any protective equipment to wear while removing the scraps until two weeks after he began his work.

In 2017, Daniels was diagnosed with terminal mesothelioma. Daniels filed a seven-count complaint against ABC and SIPA alleging that they exposed him to asbestos and caused him to develop mesothelioma. The Circuit Court of Dekalb dismissed Plaintiff's complaint, stating among other reasons, that his claims were barred by the exclusive remedy provisions of the Workers' Compensation Act.

On appeal, Daniels' widow argued that the court erred in dismissing his complaint pursuant to the Act and the Workers' Occupational Diseases Act. Both acts have provisions providing an exclusive remedy by which an employee can recover against an employer for work related disease or injury. However, in *Daniels* the court highlighted that an employee could escape the exclusive remedy provision of the Act, if they show their injury was not accidental, did not arise from their employment, was not received during employment, nor compensable under the Act. In considering whether the employee met the aforementioned elements, to escape the exclusive remedy provisions, it is important that a valid contract exist between the employer and employee exist.

The court determined that there was no valid contract between Daniels and ABC. When ABC directed Daniels to clear the debris containing asbestos, it violated the Commercial and Public Building Asbestos Abatement Act because ABC was not licensed to remove

asbestos material. As for the alleged employment contract between ABC and Daniels, the contract was unenforceable, a contract requiring someone to do something that is illegal is the equivalent to there being no contract at all. Since there was no valid contract between Daniels and ABC, the exclusive remedy provisions of the Act did not prevent Daniels from bringing a suit against ABC.

Daniels v. Venta Corp., 2022 IL App (2d) 210244

Q: *Does a medical treatment provider have a private right of action against an employer and insurer for unpaid medical bills?*

A: No.

OSF Healthcare ("OSF") provided treatment for an employee of Gallagher Bassett Services, Inc. ("Gallagher"). Great Dane, the employer's insurance provider, paid $43,486.99 in medical bills. However, $96,631.31 remained unpaid as the expenses were in dispute. OSF filed a complaint against Gallagher and Great Dane for the unpaid balance. Gallagher and Great Dane filed a Motion to Dismiss, arguing that OSF lacked standing to sue, and the Act did not provide a private right of action to medical service providers.

The motion was granted and on appeal, OSF argued that Section 8.2 of the Act, which states when medical treatment providers are to be paid, allowed it to recover the unpaid medical bills. The court, however, stated that this section, nor any other sections of the Act, expressly grant the provider the right to sue for unpaid medical bills.

The court did state that a private right of action exists if: the plaintiff is a member of the class to be benefitted by the statute, their injury is one the statute was designed to protect, the private right of action is consistent with the purpose of the statute, and the private right of action is necessary to provide the plaintiff with an adequate remedy. OSF could not meet any of these elements.

The purpose of the Act is to provide compensation to employees for injuries they sustained while working. Medical providers may receive some benefit from the Act, the court stated, but the benefit is incidental, and they were not a member of the class in mind. The court also noted that OSF could not show that the private right of action was necessary to provide it an adequate remedy. OSF conceded that filing an action against the employer and insurance company was not its only remedy; it could have sued the employee for payment of the remaining balance. For these reasons, OSF lacked standing to sue the employer and insured for the unpaid bills.

OSF Healthcare System v. Great Dane, 2022 IL App (3d) 210227-U

Q: *Do the exclusive remedy provisions of the Act extend to a general contractor who paid workers' compensation insurance premiums and benefits for a subcontractor and its employees?*

A: No.

In *Munoz*, the plaintiff filed a suit against general contractor, Bulley & Andrews, LLC. (Bulley & Andrews), for injuries he sustained while working as an employee of its subcontractor Bulley & Andrews Concrete Restoration, LLC. (Bulley Concrete). The circuit court of Cook County dismissed Munoz's suit, stating that Bulley & Andrews was immune from suit due to the exclusive remedy provisions of the Act. On appeal, the court affirmed the circuit court's judgment. Munoz then appealed to the Illinois Supreme Court.

At the Supreme Court, at issue was whether Bulley & Andrews, as the parent company and general contractor of Bulley Concrete, was also afforded the protections of the exclusive remedy provisions of the Act. The Court ruled that the exclusive remedy provisions only applied to the immediate employer of the employee. Here, Bulley & Andrews was not Munoz's immediate employer. The Court further added that the Act does not grant nonemployers the ability to acquire immunity by paying workers' compensation insurance premiums on behalf of the direct employer, as Bulley & Andrews did.

Because the exclusive remedy provisions did not apply to Bulley & Andrews, Munoz was not barred from bringing a suit against the company.

Munoz v. Bulley & Andrews, LLC, 2022 IL 127067

Q: *Is an employee's loss of the ability to maintain their privacy rights compensable under the Act?*

A: No.

In *McDonald*, Plaintiff filed a putative class action suit against defendant employer Symphony Bronzeville Park, LLC. (Symphony). McDonald alleged that Symphony violated the Biometric Information Privacy Act (BIPA) and her privacy rights by collecting, using, and storing her biometric information, fingerprints, without providing written notice. Under BIPA, a private entity cannot collect, capture, or otherwise obtain a person's biometric information unless it first informs the individual, in writing, that their biometric information is being collected or stored, informs the individual, in writing, of the specific purpose and length of time for which the information is being collected, stored, and used, and lastly the entity must receive a written release from the induvial, whose biometric information is to be collected, stored, and used.

McDonald alleged in her complaint that when she was an employee of Symphony, the company used a fingerprint time keeping system, but she was never given the written notices required under BIPA. She alleged that the employer's failure to comply with BIPA, resulted in her privacy rights being violated. Symphony filed a motion to dismiss, arguing that the Act preempted claims by the employee against the employer under the privacy

act. The circuit court denied the motion, stating that the injury McDonald suffered involved loss of the ability to maintain her privacy, which was not an injury compensable under the Act. Symphony filed a motion to reconsider, and certified a question to the Illinois Supreme Court which was "Do the exclusivity provisions of the Act bar a claim for statutory damages under BIPA?"

The Supreme Court stated that the exclusivity provisions of the Act do not bar claims for statutory damages under the Act. The Court noted that the Act is remedial in nature, its purpose is to provide financial protection for injured workers until they can return to the workforce. The exclusivity provisions in Sections 5(a) and 11 of the Act preclude an employee from suing their employer, however; the Court noted, an employee can circumvent the provisions if the remedy is not compensable under the Act. The Court stated that the circuit court was correct in its reasoning that the loss that McDonald suffered was the loss of the ability to maintain her privacy, not a psychological or physical injury compensable under the Act. The Court finally added that the Act was not designed to regulate or deter employer conduct, but to compensate injured employees; thus, McDonald's Privacy Act claim was not within the scope of the Act.

McDonald v. Symphony Bronzeville Park, LLC, 2022 IL 126511

Q: *Are penalties and attorney's fees under Sections 19(K), (l) and 16, appropriate when the employer has made TTD payments and paid all medical bills presented?*

A: No, not when the employer has not acted in bad faith.

In this case, the claimant was injured during a trip and fall at work. In August of 2019, the claimant's physician placed her on "no work" status and in September of 2020 her physician recommended surgery, but the insurance provider would not authorize the procedure. For over one year surgery was not authorized, and TTD benefits were not paid from August 2019 to September 2020.

The claimant filed a petition for a 19(b) immediate hearing, and sought penalties and attorneys' fees under sections 19(k), 19(l), and 16. The arbitrator awarded TTD benefits from August 2019 to September 2020; however, they declined to impose penalties and fees stating that it was not enough for the claimant to show that the employer failed, neglected, or refused to make payments or unreasonably delayed payment without good and just cause. Instead, the claimant would need to show that the employer had a vexatious delay in payment.

The arbitrator stated that the employer did not act in bad faith by disputing the claim based on causal connection between injury and current condition. Further, they noted that the employer made payments of TTD benefits, and medical treatment, so the employer's delaying payment while it sought to clarify claimant physician's opinion was not unreasonable. Lastly, the arbitrator noted that while the employer did fail to pay some medical bills, their failure to pay was not in bad faith because the employer was not told about the existence of the bills.

The cumulative actions of the employer were not found to be unreasonable and did not prove a "callousness" required for imposing penalties and fees under sections 19(k), 19(l), and 16. The Commission adopted the decision of the arbitrator.

Lopez v. People 4U, Inc., No. 19WC24975, 2022 Ill. Wrk. Comp. LEXIS 1

Q: *Is an employee's sexual assault by their supervisor compensable under the Act?*

A: Yes

In October 2017, the claimant reported a sexual assault by her supervisor. When she went to the hospital for a sexual assault exam, she then revealed that her supervisor had consistently been sexually assaulting her throughout her employment. At arbitration, one of the many disputed issues was whether the claimant's sexual assault was an accident that arose out of the course of her employment.

The employer argued that claimant did not sustain a work-related accident because the assault by her supervisor was personal to her, however; the arbitrator disagreed. The Commission agreed with the arbitrator's conclusion and further added that sexual assault is a physical bodily injury crime in the state of Illinois, and for the purpose of these crimes bodily harm may be shown by either actual injury such as bruises or may be inferred based on common knowledge. The Commission reasoned that it was proper to infer that sexual assault was likely to involve physical trauma, and it was appropriate that the claimant's injury be characterized as physical trauma, which is compensable under the Act.

Finally, the arbitrator noted that it is settled that physical assault by a coworker can constitute an accidental injury under the Act. The claimant's sexual assaults by her supervisor were found to be work-related accidents that arose in and out of the course of her employment, and her injury was compensable under the Act.

Kinsey v. State of Illinois – IL Youth Center St. Charles, NO. 17WC 34354, 2022 Ill. Wrk. Comp. LEXIS 90

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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.
            a) Injuries due to unexplained falls from a level surface to the same level surface are statutorily excluded from compensability. § 85.61(7)(c).
         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 pneumoconiosis.
            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
                - 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 "dependents" 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.*
         iii. analyze the unexpected or unusual nature of the injury inducing event without regard to the claimant's own particular duties. *Tripp v. Scott Emergency Commc'n.*
   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 nonresident of Iowa, but for whom services are performed within Iowa by any employee.
   3. The employer corporation, individual, personal representative, partnership, or association has the necessary minimum contact with Iowa.
   4. 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 benefit 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 represents(n/2 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 $1/50^{th}$ 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:

i. The employee returns to work, or:
ii. 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 *in writing* 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.
    a. An offer of suitable work must be in writing and include the details of lodging, meals, and transportation as well as set forth that any refusal by the employee must be communicated in writing and that they will not be compensated during that period.

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 *in writing* 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.
    a. An offer of suitable work must be in writing and include the details of lodging, meals, and transportation as well as set forth that any refusal by the employee must be communicated in writing and that they will not be compensated during that period.

C. Permanent Partial Disability (PPD) – § 85.34
1. Scheduled Member Injuries – "Loss of function"
    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 from 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, and adherence to these guidelines is compulsory.
        ii. As of 2017, shoulders are included as scheduled members as codified in § 85.34(2).
    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;
        - 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.
4. An employee does not receive industrial disability if they return to work or are offered work in which they would receive the same or greater salary, wages, or earnings than they received at the time of injury.
    a. In this instance, permanency is based on the functional impairment.

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.
    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 *in writing* 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.
    a. An offer of suitable work must be in writing and include the details of lodging, meals, and transportation as well as set forth that any refusal by the employee must be communicated in writing and that they will not be compensated during that period.

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. Applies only to weekly payments, not medical expenses.
4. Interest is calculated in a 3-step process as follows:
    a. **Step 1:**
        i. For interest on benefits that accrued **prior to July 1, 2017**:
            - 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.
            - Locate the interest multiplier from that line from the same table in column B.
            - Multiple the weekly benefit amount by the interest multiplier to determine interest payable.

OR

        ii. For interest on benefits that accrued **July 1, 2017 or after**:
            - Interest rate is calculated at the Treasury rate plus 2%.
            - Interest is calculated using the following formula:

$$(N/2) \times (N-1) \times P \times r/52 = \text{interest}$$

Where:
- N = number of continuous weeks of disability
- P = the weekly benefit rate
- r = interest rate

b. **Step 2:**
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
- P = principal (the total # of weeks/days to 3 decimal points of compensation due x compensation rate)
- R = rate of interest (10%)
- 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 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.
         i. A positive drug/alcohol test creates a rebuttable presumption that employee was intoxicated and that intoxication was a substantial cause of the work injury. That presumption is rebuttable by the worker if they can show they were not “intoxicated” and/or that the intoxication did not substantially cause the work 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. *As of March 15, 2023, if all parties are represented by counsel, a commutation is presumed to be in the best interests of the claimant, and the parties may stipulate to a different period of compensation. This change to the Administrative Code also removes the language that "a commutation of less that ten weeks' benefits is presumed to be not in the best interest of the claimant."*
        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: What is the definition of a "shoulder" under Iowa Code 85.34(2)(n)?

A: A "shoulder" is defined in the functional sense to include the glenohumeral joint as well as all of the muscles, tendons, and ligaments that are essential to function.

Under section 85.34, the classification of a workers' compensation claimant's injury as either scheduled or unscheduled determines the extent of the claimant's entitlement to permanent partial disability benefits. If an injury is classified as a scheduled member injury to the shoulder under Iowa Code section 85.34(2)(n), the claimant is eligible for a percentage of 400 weeks of pay based on the impairment rating of the injury. In contrast, if an injury is classified as an unscheduled whole-body injury under section 85.34(2)(v), the claimant is eligible for payment for the functional impairment resulting from the injury on a 500-week schedule and additional compensation if the claimant did not return to work earning the same or greater wages as before the injury.

Claimants in both *Deng* and *Chavez* contended "shoulder," under section 85.34(2)(n), is narrowly defined to only include injuries located within the glenohumeral (shoulder) joint. Under this definition, damage to the proximal side of the joint would be considered an unscheduled whole-body injury, damage to the distal side of the joint would be considered a scheduled arm injury, and damage within the glenohumeral joint would be considered a scheduled shoulder injury.

The Court stated, "Viewing section 85.34(2) in its entirety, it is apparent that the legislature did not intend to limit the definition of "shoulder" solely to the glenohumeral joint. With this decision, the shoulder and its attendant muscles and ligaments, including rotator cuff injuries, remain scheduled member injuries in Iowa. Recovery for these injuries under the Act is limited to the value of the functional impairment to the upper extremity out of 400 weeks of benefits for the total loss of a shoulder.

Deng v. Farmland Food, Inc. No. 21-0760 (Iowa 2022); *Chavez v. MS Technology LLC*, No. 21-0777 (Iowa 2022).

Q: Is an employee who sustains bilateral shoulder injuries arising out of a single incident entitled to compensation under industrial disability analysis?

A: Yes. If an employee sustains injuries to both shoulders as the result of a single incident, they are to be compensated under the "catch-all" provision of section 85.34(2)(v) which evaluates permanent impairment under an industrial disability analysis.

In *Carmer v. Nordstrom, Inc.*, the claimant sustained a compensable right shoulder injury. The employee subsequently developed a left shoulder injury due to overuse.

The deputy commissioner determined the left shoulder injury was a sequela from the accepted right shoulder injury and, accordingly, both shoulder injuries arose out of a single occurrence. The deputy commissioner further found these injuries to be scheduled

member injuries which failed to extend into the claimant's body as a whole.

With this finding, the claimant asserted her injuries should be compensated industrially under the "catch-all" provision of Iowa Code section 85.34(2)(v). Conversely, Nordstrom argued an injury to the shoulder is to be compensated under the schedule pursuant to Iowa Code section 85.35(2)(n) and the claimant was therefore limited to a functional disability analysis. However, following an analysis of the 2017 legal changes, the deputy commissioner sided with the claimant and concluded that an injury to the right shoulder and a sequela injury to the left shoulder caused by the effects of the original injury must be compensated industrially under Iowa Code section 85.34(2)(v) because "the statute does not contain a provision addressing this situation under the schedule."

The Commissioner affirmed this finding on appeal. His most notable reason for coming to this conclusion was the Iowa legislature's failure to add the word "shoulder" to section 85.34(2)(t)—a provision which sets forth a list of two scheduled members that when injured as the result of a single accident are to be compensated on a 500-week basis—when making changes to Iowa workers' compensation laws in 2017. The Commissioner deemed this omission to be significant in light of the legislature's re-categorization of a shoulder injury from an unscheduled injury to a scheduled injury.

Accordingly, as the law currently stands with the agency, permanent impairment in a case where bilateral shoulder injuries arise from a single accident should be compensated under an industrial disability analysis pursuant to section 85.34(2)(v).

Carmer v. Nordstrom, Inc., No. 1656062.01, 2021 WL 4243190 (Arb. Sept. 13, 2021) & *Carmer v. Nordstrom, Inc*., No. 1656062.01, 2021 WL 6206792 (App. Dec. 29, 2021).

Q: How is a distal clavicle excision in Iowa rated under the AMA Guides?

A: Distal clavicle excision receives a 10% impairment as an acromioclavicular arthroplasty under Table 16-27 of the AMA guides but also requires a 25% multiplier making the total impairment rating 2.5%.

In *Jay v. Archer Skid Loader Serv., LLC,* a Claimant sustained a shoulder injury and underwent a revision procedure including a distal clavicle excision. Claimant had an IME who assigned a 5% impairment for loss of range of motion and a 10% impairment for the distal clavicle excision under Table 16-27 of the AMA Guides. The treating physician did not assign an impairment rating for the distal clavicle excision providing a detailed opinion stating the AMA Guides Table 16-27 is for "arthroplasty procedures or joint replacements, which a distal clavicle excision is not." The Deputy adopted the IME opinion as the legislature mandated that functional impairment be determined by the 5th Edition AMA Guides. Upon appeal it was argued that the IME should have applied a modifier to the 10% rating. The Commissioner found that when a Claimant undergoes a revision procedure including a distal clavicle excision or Mumford procedure and receives an impairment rating under Table 16-18 of the AMA Guides, the appropriate multiplier for the acromioclavicular joint is 25%. Thus, resulting in a 2.5% impairment for a distal clavicle excision.

Jay v. Archer Skid Loader Serv., LLC, File No. 19003586.01 (App. Dec. Aug. 23, 2022).

Q: Does trapezius pain or distal clavicle resection after a shoulder injury lead to a body as a whole injury?

A: No. Distal Clavicle resection is to improve the glenohumeral joint function which is part of the shoulder, not a separate injury, and trapezius pain alone does not extend beyond the shoulder injury.

Clickner v. Prairie Farms Dairy, Inc., File No. 20000273.01 (Arb. Dec. July 1, 2022).

Q: Can a defendant claim credit for a pre-amendment non-scheduled member shoulder injury?

A: Yes. Despite the shoulder being compensated as an injury to the body as a whole prior to the 2017 amendment, the defendant may now claim credit for the shoulder injury as a scheduled member. This issue has been remanded back to the Commissioner to determine the appropriate credit to be given to the prior injury.

P.M. Lattner Mfg. Co. v. Rife, No. 22-1421, 2023 WL 3862594, at *5 (Iowa Ct. App. June 7, 2023).

Q: Is an employee who sustains permanent disability to his right arm and right shoulder as the result of a single accident entitled to industrial disability benefits under Section 85.34(2)(v)?

A: Yes. When an employee sustains an injury to his arm and shoulder as the result of a single accident, they will be compensated under an industrial disability analysis pursuant to Section 85.34(2)(v).

In *Anderson v. Bridgestone Americas Inc.*, the claimant sustained permanent disability to his right arm and permanent disability to his right shoulder as the result of a single accident. When determining how to compensate the claimant for his permanent disabilities, the deputy commissioner analyzed four potential ruling subsections of Iowa Code section 85.34(2): (m), (n), (t), and (v).

Subsections (m) and (n) were quickly rejected as the appropriate choice since the claimant sustained a loss to *both* his arm *and* shoulder, and subsections (m) and (n) are limited to the loss of *either* an arm *or* a shoulder.

Subsection (t) was similarly rejected as “shoulder” was not included in the list of scheduled members which may be compensated pursuant to the subsection when the loss results from a single incident. A noted omission by the legislature in 2017.

With the claimant’s disability failing to fall into any subsection listed in “a” through “u,” Subsection (v), which acts as a “catch-all” provision was determined to be the appropriate statute ruling compensability. With this finding, the claimant was to be compensated on the basis of an unscheduled injury based on a 500-week schedule and an industrial disability analysis was triggered.

Accordingly, when an employee sustains permanent disability to his right arm and right shoulder as the result of a single work injury, the employee will be entitled to receive industrial disability benefits pursuant to section 85.34(2)(v).

Anderson v. Bridgestone Americas Inc., No. 5067475, 2021 WL 4132332 (Arb. Sept. 2, 2021).

Q: Is an employer who fails to authorize surgery recommended by the treating physician and fails to pay weekly benefits following surgery subject to penalty when they are continuing to investigate the claim?

A: Yes. When employer lacks evidence to support their claimed effort to investigate and fails to contemporaneously convey the basis for its delayed decision or denial of benefits, penalty benefits are appropriate.

In *Foster v. East Penn Mfg. Co.*, the claimant sustained an accepted work-related injury. The employer paid for the initial medical treatment and benefits associated with the claimant's time off work which included a first surgery which failed to wholly fix her condition. As a result, the doctor recommended a second surgery and the claimant was again taken off work following the procedure. However, the employer refused to authorize the second surgery or pay temporary total disability (TTD) benefits and the agency imposed penalty against the employer as a result. The penalty was affirmed on appeal by the District Court. Defendants appealed arguing an award of penalty benefits was unsubstantiated by the record as (1) the delay was necessary to investigate the claim, (2) a reasonable basis existed to delay the payment of benefits, and (3) there was a good faith dispute to the claimant's entitlement to benefits. The employer further contended that even if penalty benefits were required, nothing is owed as a credit for other benefits paid should apply.

However, the Iowa Court of Appeals held that because the employer (1) had a lack of evidence to support their claimed effort to investigate and (2) failed to contemporaneously convey its basis for its delayed decision making or denial at the time of the denial, the delay in benefits was not "justified by necessary time for investigation or a reasonable basis to contest the claim" and, accordingly, penalty benefits were appropriate.

The court further held the employer was not entitled to credit for prior permanent partial disability (PPD) benefits paid as both parties stipulated that PPD benefits were not yet at issue. Accordingly, the court was unable to determine if the amount voluntarily paid was duplicative and the agency's finding that the employer was not due a credit for TTD benefits based on PPD benefits paid was affirmed.

Consequently, penalty benefits are appropriate when the employer lacks evidence of efforts to investigate and fails to contemporaneously provide the basis for its delayed decision and/or denial of benefits.

Foster v. East Penn Mfg. Co., No. 20-1738, 2021 WL 5918422 (Iowa Ct. App. Dec. 15, 2021).

Q: When an employee commits suicide after being terminated for insubordination, is their surviving spouse entitled to death benefits for a mental-mental injury?

A: No. Not when the surviving spouse (1) fails to cite any legal authority on the issue of factual causation, (2) the mental injury resulted from the employee's love for his job which was reasonably terminated as a result of his insubordination, and (3) presents no evidence offering comparison of the stress endured by "similarly situated employees" as needed to meet the legal causation burden.

In *Jackson v. Bridgestone Americas Tire Operations*, a surviving spouse sought death

benefits for a mental-mental injury after her husband's termination and resulting suicide. Before his death, the decedent had worked for the employer for twenty-eight years before being terminated for insubordination. After the decedent was notified by the employer of his termination, he shared the news with his family and returned home. Shortly thereafter, the decedent's spouse arrived home to find the decedent locked in their garage with his car running. The decedent's spouse was able to convince the decedent to come out of the garage. However, when his spouse stepped into the house, the decedent left the home, and was subsequently discovered dead at a nearby bridge. Only a few hours had elapsed between the employee's termination and his suicide.

The decedent's spouse filed a petition seeking workers' compensation death benefits with the agency. Following an arbitration hearing, the deputy commissioner concluded the claimant's mental condition and suicide were not causally related to his termination and, more succinctly, the suicide could not be traced to an injury arising out of and in the course of employment. Both the Commissioner and district court affirmed this denial of benefits.

On appeal before the Iowa Court of Appeals, the surviving spouse agreed the suicide itself would not qualify as an injury under the act, but presented a medical causation opinion which she argued, when read as a whole, unmistakably demonstrated that her husband "(1) suffered a mental injury as a result of being fired and (2) that the firing and resulting mental injury caused him to take his own life."

The Iowa Court of Appeals rejected the spouse's argument, noting that she failed to cite "any legal authority whatsoever on the issue of factual causation." However, the court continued its analysis by concluding the surviving spouse's expert opinion was based on incomplete information as it failed to take into consideration her husband's "repeated and blatant" insubordination and that it was this insubordination which resulted in his termination paired with the decedent's love for his job which resulted in any mental injury.

The court also addressed the issue of legal causation and noted that even if a mental injury occurred as the result of the decedent's termination, the surviving spouse failed to present evidence that the "resulting stress was of greater magnitude than the mental stress experienced by other workers in the same or similar jobs that were terminated for insubordination." A threshold necessary to satisfy legal causation in a mental injury cause without an accompanying physical injury.

In conclusion, for a mental injury without an accompanying physical injury to qualify as a personal injury, an employee must prove both factual and legal causation. To prove factual causation, the employee must show the injury is causally connected to his/her employment. To prove legal causation, the employee must show the mental injury "'was caused by workplace stress of greater magnitude than the day-to-day mental stresses experienced by *other workers employed in the same or similar jobs*,' regardless of their employer" (emphasis in original).

Jackson v. Bridgestone Americas Tire Operations, 973 N.W.2d 882, 2021 WL 5918032 (Iowa Ct. App. Dec. 15, 2021).

Q: Are healing period benefits late when commenced 11 days after the injury?

A: No. The first weekly benefit payment is due on the eleventh day according to section 85.32.

The Iowa Supreme Court has previously held that "The due date for the first week of healing period compensation is the eleventh day after the injury" and "The subsequent due dates fall on the day after the end of each compensation week thereafter, that is, the eighth day after the first day of each subsequent compensation week." *Goodman v. Snap-On Tools Corp.*, No. 03-0414, 2004 WL 2066941, at *3 (Iowa Ct. App. Sept. 9, 2004). This 11-day grace period, allows for an "evaluation and investigation of the injury and a determination of the correct weekly compensation rate before the first compensation payment is due." *Robbennolt v. Snap-On Tools Corp*., 555 N.W.2d 229, 235 (Iowa 1996).

City of Maxwell v. Marshall, 967 N.W.2d 566, 2021 WL 4889238 (Iowa Ct. App. Oct. 20, 2021).

Q: When an employer obtains an opinion from a medical expert addressing causation but does not assign an impairment rating, is the employee entitled to an IME under section 85.39?

A: Yes. If the injury is determined to be compensable, the employer will be held responsible for reimbursement of the reasonable cost of the employee's IME.

In Kern v. Fenchel, Doster & Buck, P.L.C., the employer sent the claimant for an examination with a doctor who opined the claimant's injuries were not work related. With this finding, the employer denied any liability for the injuries, and the claimant filed a claim with the Iowa Workers' Compensation Division. The claimant subsequently underwent an independent medical evaluation (IME) where both causation and permanent impairment were found. At hearing, the claimant sought reimbursement for her IME fees which the deputy commissioner denied after finding the claimant failed the comply with the procedure described in Iowa Code section 85.39 to entitle her to an evaluation at the insured's expense since no impairment rating was provided at claimant's initial evaluation by the insured' selected provider.

While this denial of reimbursement was upheld at all early stages of appeal and petition for rehearing, the Iowa Court of Appeals found the IME cost should have been reimbursed as a determination that the claimant's injuries were not caused by her employment is "clearly a disability evaluation" since it is effectively an opinion that the claimant suffered no impairment as the result of her employment. In other words, an opinion on lack of causation is tantamount to a 0% impairment rating.

Kern v. Fenchel, Doster & Buck, P.L.C., 966 N.W.2d 326, 2021 WL 3890603 (Iowa Ct. App. Sept. 1, 2021).

Q: As an employer, what am I responsible to pay for regarding an IME?

A: An employer is only responsible to pay for an impairment rating at a typical fee as designated by the medical provider.

In *MidAmerican Construction LLC v. Sandlin*, the court delt with the interpretation of the revisions of section 85.39. The revisions to 85.39(2) had indicated that the "reasonable

fee for a subsequent examination by a physician of the employee's own choice" was to be reimbursed once a doctor retained by the employer had issued a rating. Those revisions had also indicated that the determination of the reasonableness of the fee "shall be based on the typical fee charged by a medical provider to perform an impairment rating in the local area where the examination occurred." 85.39(2).

In this case Dr.Taylor had previously indicated that the impairment rating was $500, and the remaining balance of the $2020.00 report was the cost of the IME. The Court held that the impairment rating was only $500 and therefore the cost to the employer under 85.39(2) encompassed the “reasonable fee” but to go beyond that “would authorize payment of expanded examination, report, and intensive review of medical records, in contravention of what the legislature has determined.” Thus, the reimbursement of the IME is limited to the cost of the impairment rating pursuant to 85.39.

MidAmerican Cosnt. LLC v. Sandlin, No. 22-0471 (Iowa App. Feb. 22, 2023).

Q: Is an employer responsible to reimburse the costs of the IME if the employee did not comply with the requested evaluations by the defendant?

A: No. If the employee did not comply with the evaluations, then pursuant to Section 85.39(2) the employer is responsible to provide reimbursement for an impairment rating rather than the cost of the examination in its totality.

In *P.M. Lattner Mfg. Co. V. Rife*, the claimant sustained an injury to the right shoulder which resulted in a full commutation of benefits. The claimant later injured the shoulder again and obtained an IME for the shoulder, as well as a claimed right ankle injury. The Commissioner held that the claimant was entitled to reimbursement for the IME in full. The Appeals Court, citing *MidAmerican Const. LLC v. Sandlin*, held that the employer was not responsible for reimbursing costs from an examination that did not relate to the impairment of the compensable right shoulder. Thus, the impairment rating of the right ankle was not related and was not to be reimbursed by the employer.

P.M. Lattner Mfg. Co. v. Rife, No. 22-1421 (Iowa App. June 7, 2023) & *MidAmerican Cosnt. LLC v. Sandlin*, No. 22-0471 (Iowa App. Feb. 22, 2023).

Q: For the purposes of benefits under Iowa’s Second Injury Compensation Act, when an employee sustains permanent impairment to the body as a whole that also causes impairment to a qualifying scheduled-member body part, do they have a “first qualifying injury” against the Fund?

A: No. A condition to the body as a whole that “merely affects” an enumerated member does not constitute a “first qualifying injury.”

In *Blake v. Second Injury Fund of Iowa*, the claimant sought benefits from the Second Injury Fund (the Fund) under the assertion that impairment to her eye, caused by her Graves’ disease, constituted a “first qualifying injury” within the context of Iowa’s Second Injury Compensation Act. The workers’ compensation Commissioner rejected this claim and denied benefits from the Fund. On judicial review, the Iowa Court of Appeals affirmed the district court’s ruling and upheld the Commissioner’s denial of the claimant’s claim against the Fund.

The court came to this conclusion upon differentiating an injury to an enumerated member

which also causes impairment to the body as a whole, from an impairment to the body as a whole that also causes impairment to an enumerated, scheduled member.

Holding, in summary, an injury to an enumerated member constitutes a "first qualifying injury" even when that injury also causes impairment to the body as a whole. However, the inverse of this, an injury to the body as a whole that also causes impairment to an enumerated member does not constitute a "first qualifying injury."

Blake v. Second Injury Fund of Iowa, 967 N.W.2d 221, 2021 WL 4304274 (Iowa Ct. App. Sept. 22, 2021).

Q: When an employee sustains a tear to the quadriceps tendon, is their injury compensated as a scheduled-member injury of the leg?

A: No, it would be considered a whole body injury. Accordingly, an industrial disability analysis is triggered.

In *Masterbrand Cabinets v. Simons*, the claimant sustained an undisputed work-related injury to his right quadriceps tendon. Following an arbitration hearing, the claimant was awarded permanent partial disability benefits based on an unscheduled injury. This award was affirmed by the workers' compensation Commissioner and District Court on appeal.

Masterbrand Cabinets continued to appeal this finding on the contention that the claimant's right quadriceps tendon tear injury was confined to his leg—limiting his benefits to a scheduled loss. However, in consideration of three doctors' opinions identifying impairment of the claimant's right hip resulting from his torn quadriceps tendon, and the claimant's credible testimony at the arbitration hearing, the commissioner's finding of an injury to the claimant's body as a whole was upheld.

Masterbrand Cabinets v. Simons, 967 N.W.2d 224, 2021 WL 4304957 (Iowa Ct. App. Sept. 22, 2021).

Q: When the party seeking judicial review of an alternate medical care decision fails to file a transcript of the agency hearing, will the alternate medical care decision be upheld?

A: Yes.

It is the appealing party's responsibility to file a transcript of the agency hearing. Without the agency hearing transcript, there is an insufficient record to allow the court to accept the party seeking judicial review's claim that the agency decision was not supported by substantial evidence. And since the court does not presume error, in the absence of agency hearing transcript an alternate medical care decision will be affirmed.

Dotts v. City of Des Moines, 965 N.W.2d 632, 2021 WL 3076305 (Iowa Ct. App. July 21, 2021).

Q: Is an insurance carrier who inadvertently pays workers' compensation benefits to an employee entitled to reimbursement from another insurer when a petition for contribution, pursuant to section 85.21, is not filed until after the arbitration hearing?

A: No. An insurance carrier must seek and obtain a Section 85.21 order *before* the arbitration hearing in order to pursue reimbursement claims from another insurer.

The claimant in *American Home Assurance v. Liberty Mutual Fire Ins. Co*. filed a petition for workers' compensation benefits against his employer and its insurer, American Home Assurance (American Home). Following an arbitration hearing, 125 weeks for permanent partial disability benefits were awarded by a Deputy Commissioner, and later affirmed by the Commissioner. American Home paid the awarded benefits.

Three years after American Home's final payment of weekly benefits, the claimant filed a review-reopening petition. It was at this time American Home discovered it was not the insurer on the claimant's date of injury. Accordingly, American home filed an "Application for Payment Benefits Under Iowa Code Section 85.21." The application was subsequently granted by a Deputy Commissioner with an order authorizing American Home to "petition, cross-petition, or intervene in proceedings before this agency . . . to seek determination of liability and reimbursement from another carrier." Pursuant to Iowa Code section 85.21, American Home then filed a petition for contribution seeking reimbursement from Liberty Mutual Insurance Company (Liberty Mutual) for benefits paid to date as well as any future benefits "found to be due as a result of [the claimant's] currently pending" review-reopening petition.

While a deputy workers' compensation commissioner concluded American Home was entitled to such contribution, the Commissioner reversed the portion of the deputy commissioner's decision requiring reimbursement for payments made before the order authorizing a reimbursement claim was issued. The Commissioner reasoned that "Because American Home failed to seek an Iowa Code section 85.21 consent order prior to the arbitration hearing, Liberty Mutual is not liable for contribution to American Home for benefits ordered to be paid and paid pursuant to the arbitration decision." On judicial review the District Court reversed the agency's final decision finding there was no time limitation on reimbursement actions or a carrier's right to recovery.

However, on further appeal, the Iowa Court of Appeals agreed with the Commissioner's finding and limited American Home's reimbursement claim to benefits paid after the section 85.21 order was obtained. The Supreme Court of Iowa later affirmed under the same reasoning.

In short, an insurer is not afforded an indefinite period of time to seek reimbursement.

American Home Assurance v. Liberty Mutual Fire Ins. Co., -- N.W.2d --, 2021 WL 2080934 (Iowa June 10, 2022).

Q: Can a previously agreed upon situs of injury be altered in a review-reopening action?

A: No. When there is prior settlement agreement and written stipulation which identify the part of the body affected or disabled, the employee is bound to that judicial acceptance and is estopped from attempting to claim a different injury.

In *Pesicka v. Snap-On Logistics Co.*, the parties entered into a settlement agreement pursuant to Iowa Code Section 85.35(2). As part of the settlement agreement, the parties stipulated a 13% permanent partial disability to the right leg. Following settlement, the claimant underwent eight additional surgeries. Two of which resulted in the amputation of all five toes on the claimant's right foot.

Claimant subsequently filed a petition for review/reopening relief asserting his right leg condition had worsened and he was seeking an increase in benefits. As part of his claim, while not included in the petition, the claimant asked the agency to award increased compensation for his lost toes.

However, the deputy commissioner, the commissioner, the district court, and the Iowa Court of Appeals found the claimant was unable to claim an award pertaining to the loss of his toes as his settlement agreement, and the review-reopening hearing report, contained the stipulation that claimant's injury was limited to his right leg. The Court of Appeals reasoned that to disregard the stipulation would prejudice the employer as they did not have adequate notice to dispute the level of impairment to the right leg, foot, and five toes.

In conclusion, the situs of injury in a review-reopening action will be limited to what was previously agreed upon in a settlement agreement and/or stipulated to at hearing.

Pesicka v. Snap-On Logistics Co., 965 N.W.2d 638, 2021 WL 3076551 (Iowa Ct. App. July 21, 2021).

Q. If an arbitration decision found no permanent impairment can a Claimant file a review/reopening to pursue a claim for permanent impairment?

A: Yes. Res Judicata does not prevent the review or reopening if the symptoms of permeant disability arise.

In *Green v. North Central Iowa Regional Solid Waste Authority*, a claimant filed a review of a 2014 arbitration decision where the Deputy concluded that claimant was entitled to temporary disability benefits for a cervical strain, closed head trauma and shoulder strain but had not proved any permanent injury resulting in permanent disability benefits. The Claimant alleged the temporary disability had worsened over time into permanent disability. The Iowa Supreme Court held that a prior determination in workers' compensation proceeding that injuries were not permanent did not bar a review and reopening proceeding when the Claimant's injuries had worsened overtime into permanent disability.

Solid Waste Authority paid temporary benefits to Green during her initial period of recuperation from injury. And on remand from the District Court in the earlier case, the Commissioner ordered it to make additional payments for medical bills and lost wages during the several months after the incident. The Iowa Supreme Court held the prior

payments made as awarded by the Commissioner satisfied the statutory reopening requirement of "an award for payments or agreement for settlement." Iowa Code section 86.14(2).

Green v. N. Cent. Iowa Reg'l Solid Waste Auth., 989 N.W.2d 144, 149 (Iowa 2023), reh'g denied (May 9, 2023).

Q: Does the Iowa workers' compensation statute require employees with high stress jobs to prove mental injury claims occurred due to hyper-unexpected causes or strains?

A: No. Claimants meet the legal causation standard by showing the injury was induced by an unexpected cause or unusual strain *without* regard to the claimant's own particular duties.

In *Tripp v. Scott Emergency Communication Center*, the Court determined that Iowa's workers' compensation statute does not place a higher bar of proof for emergency responders claiming benefits for trauma-induced mental injuries suffered on the job than workers in other roles with identical injuries. Iowa Code § 85.3(1) establishes a worker's eligibility to receive compensation if a personal injury "aris[es] out of and in the course of employment."

With regard to purely mental injuries, those that do not have an associated physical injury, a claimant must prove both medical causation and legal causation. Medical causation is that the mental condition was in fact caused by employment activities. Legal causation, however, requires a claimant to show that the mental injury resulted from "workplace stress of a greater magnitude than the day-to-day mental stresses experienced by other workers employed in the same or similar jobs, regardless of their employer." *Dunlavey v. Economy Fire & Casualty Co.*, 526 N.W.2d 853, 858. But when the mental injury is based on a sudden traumatic event that comes from an unexpected cause or unusual strain, the courts have said that the legal causation standard is met. See *Brown v. Quik Trip Corp.*, 641 N.W.2d 725, 729.

The Tripp case defined a new test for what qualifies as an unexpected cause or unusual strain. Mandy Tripp worked as an emergency dispatcher for 16 years until she developed PTSD from a disturbing call from a mother reporting the murder of her baby. At the hearing before the Deputy Workers' Compensation Commissioner, the defense counsel presented multiple witnesses who worked as dispatchers who also reported receiving calls of infant deaths. The Deputy commissioner denied the petition for benefits because dispatchers "routinely take calls involving death and traumatic injuries" and that "Tripp failed to prove the call was unusual or unexpected."

However, the Iowa Supreme Court said that the ruling unduly placed upon first responders a burden of proving hyper-unexpected causes and hyper-unusual strains to qualify for benefits that less hazardous professions receive under a much lower bar. The Court put forth a new test which states, when a purely mental injury is traceable to a readily identifiable work event, the claimant proves legal causation by meeting the test we set forth in *Brown* by analyzing the unexpected or unusual nature of the injury inducing event without regard to the claimant's own particular duties." In other words, no longer are claimants required to prove unexpected causes or unusual strains against their

particular duties, but against the general population.

Tripp v. Scott Emergency Commc'n and Iowa Municipalities Workers' Comp. Assoc., -- N.W.2d --, 2022 WL 1815223 (Iowa 2022).

Q: Do the Iowa Supreme Court's COVID-related supervisory orders from April 2, 2020 and May 8, 2020—tolling the statutes of limitations, statutes of repose, and "similar deadline[s] for commencing an action in district court"—apply to the 30-day deadline for petition for filing a petition for judicial review of a final agency decision in a workers' compensation case?

A: No. The 30-day deadline to file a petition for judicial review, is an appellate deadline and jurisdictional prerequisite governed by Iowa Code section 17A.19(3), and is not considered a "statute of limitations, statute of repose, or similar deadline for commencing an action in district court." Accordingly, a proceeding for judicial review of a final agency decision must be commenced by filing of a petition with the district court within 30 days of the date when the claimant's application for rehearing had been deemed denied.

Askvig v. Snap-On Logistics Co., 967 N.W.2d 558 (Iowa Nov. 17, 2021).

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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 months 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)):

1. 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: Must a claimant file a claim for compensation before the Oklahoma Workers' Compensation Commission before one year to defeat the Statute of Limitation?

A. Maybe. In *Schumberger Technology Corp. v. Paredes*, the Oklahoma Supreme Court found that an injured worker in Oklahoma has ***at least*** one year from the date of an injury in which to file his or her claim.

In *Paredes*, the Court interpreted 85A O.S. Sec. 69, "[a] claim...shall be barred unless it is filed...within one (1) year from the date of injury or, if the employee has received benefits under this title for injury, six (6) months from the date of the last issuance of benefits" finding the Legislature intended for injured workers to have ***at least one year*** from the date of an injury in which to file a workers' compensation claim before the Workers' Compensation Commission.

The employer's insurance company admitted the injury and voluntarily provided treatment for two months. A Form 3 was filed 10 months after the accident, well within the one-year SOL. However, the insurance carried denied the claim, alleging that the SOL was only 8 months. The ALJ and the Commission en Banc ruled that the SOL was at least one year. The carrier appealed and the Supreme Court retained the appeal.

Justice Gurich opined the Legislature had created a method to extend payment of benefits beyond an arbitrary SOL, noting that "Commission's decision applied the statute as intended, which was to give the claimant the benefit of the longer period because of the employer's payment of benefits… the phrase 'whichever is greater' is superfluous."

The opinion also holds that the SOL is "not an absolute time bar." The burden is on the employer to take affirmative action. There must not only be an objection based upon the running of the SOL, but **ALSO A HEARING**.

The six months provision of Sec. 69 only extends the SOL in cases in which the employer admits the injury and pays benefits. If a badly injured worker is off four years when treatment is terminated, he or she has six months from that date to file a claim before the Commission.

Schumberger Technology Corp. v. Paredes, 2023 OK 42.

Q: May a doctor consider a claimant's expression of pain and take it into account when determining the cause of an injury to meet the "objective findings" standard for an injury?

A: Yes. In *Pilot Travel Centers v. Stephens*, the Oklahoma Supreme Court found a doctor may consider a claimant's expression of pain when determining the cause of an injury to meet the "objective findings" standard for an injury found in 85A O.S. Sec. 2(9)(c).

The decision emphasizes that subsection of the statute only prohibits consideration of expressions of pain ***under the voluntary control of the patient***. However, if pain is found during a physical manipulation, the doctor's opinion that an injury has occurred is "objective medical evidence under the statute."

Respondent argued to the Court that an IME's report was not competent objective evidence of injury because it was based entirely (so they claimed) on Claimant's expressions of pain, in opposition to the statute. However, the Court emphasized an expression of pain may ***voluntary or involuntary***.

In this case, the IME doctor conducted physical manipulation of Claimant and determined she had "pain with motion." The Court stated, the doctor may then consider, consistent with statute, the expression of pain made during physical examination, and the opinion resulting IS objective medical evidence.

In *Stephens*, the Court also found considered opinions of doctors at the Johns Hopkins School of Medicine and quoted language in their opinion in defining a rhizotomy as "a minimally invasive **SURGERY**."

Pilot Travel Centers v. Brenda Stephens, OK Supreme Court Case No. 119,260.

Q: May a claimant maintain an Intentional Tort claim in district court at the same time as a Workers' Compensation claim?

A: No. In *Kpiele-Poda v. Patterson-UTI Energy, Inc.*, the Oklahoma Supreme Court found that 85A O.S. Sec. 5(I) unambiguously permits an employee to maintain an action ***either*** before the Commission or in district court, ***but not both***.

In *Patterson-UTI Energy*, the injured employee suffered injuries to his legs and lower back while repairing a conveyor at a wellsite. He filed a workers' compensation claim, and while that claim was still pending, filed a petition asserting negligence and products liability in district court against employer, two wellsite operators, and manufacturers and distributors of conveyor.

Employee's employers moved to dismiss the district court action arguing the Administrative Workers' Compensation Act and Oklahoma precedent preclude employees from simultaneously maintaining an action before the Workers' Compensation Commission and in the district court. The district court granted each dismissal motion and certified each order as appealable.

The worker appealed the dismissal order and the Supreme Court held the district court properly dismissed Employee's intentional tort action for lack of subject matter jurisdiction due to the pending claim before the Commission.

Therefore, because the employee invoked the jurisdiction of the Commission first, by filing the workers' compensation claim, and maintained the action in that forum, he is statutorily prohibited from maintaining simultaneous action in district court, and the district court matter must be dismissed.

Kpiele-Poda v. Patterson-UTI Energy, Inc., 2023 OK 11.

Q*: If a Claimant unsuccessfully recovers workers' compensation benefits for an injury, can he then file suit in trial court and plead a claim for relief that is legally possible if an employer may have assumed the duty to provide a safer crosswalk for access to an employer designated parking lot?*

A. Yes. In *Harwood v. Ardagh Group, Ardagh Glass, Inc.*, the Oklahoma Supreme Court held that the employer may have assumed the duty to provide a safer crosswalk for access to the employer designated parking lot and therefore, the employee pled a case for relief which was legally possible. The trial court's decision was premature and the question of whether the actions of the employer were the proximate cause of the employee's injuries is a matter for a jury to decide.

In *Harwood*, the Plaintiff was struck by Defendant's automobile while leaving his work shift and attempting to cross a state highway to an employer provided parking lot. Plaintiff attempted to recover workers' compensation benefits for his injuries but was not successful since he was not injured "in the course of employment." Plaintiff then filed a lawsuit against his employer and the Defendant driver. The trial court dismissed the lawsuit against the employer for failure to state a claim upon which relief could be granted. Plaintiff appealed and the Court of Civil Appeals confirmed the decision.

Plaintiff argued that Defendant caused his injuries when he negligently failed to stop at the crosswalk and that his employer was also a cause of his injuries because the employer negligently failed to ensure adequate lighting and protection for employees crossing at the crosswalk. The employer argued that it did not have a duty to make the crosswalk safer because it did not own, operate, or control the crosswalk and because Plaintiff was not within the course and scope of employment at the time of the accident.

The Court notes that while Plaintiff's workers' compensation benefits were denied, a workers' compensation analysis is still useful in this case. Here, Plaintiff's workers' compensation benefits were denied because his injuries were not within the "course and scope of employment." However, negligence for a parking lot or crosswalk injury can be covered under tort law. The Court agrees that if there is an actionable claim for negligence in Plaintiff's case, it is covered by tort law rather than workers' compensation law and may be brought in the district court. Denial of workers' compensation benefits does not preclude such an action.

Plaintiff alleges several facts to make the argument that the employer had a duty of care. The employer provided parking for employees and instructed them to park across a busy highway. The employer stated it would make crossing the highway as safe as possible and took certain precautions such as creating a walkway with railings and placing strobe lights on the four-way stop when the crosswalk lights were out. Because the employer had previously taken steps to make the crossing safer, the employees relied on the employer to make the crossing safe, and the employer failed to do so on this occasion which increased the risk of harm to Plaintiff. Under these facts, the Court held that the trial court's dismissal for failure to state a claim for which relief can be granted was premature.

Harwood v. Ardagh Group, Ardagh Glass, Inc., 2022 OK 51.

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. 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 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 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*. 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. ***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

Q*. Is the one-year from date of injury statute of limitations period, under 85A O.S. 69(A)(1), a minimum that may be extended under certain circumstances?*

A. Yes. In *Erasmo Paredes v. Schlumberger Technology Group*, the Oklahoma Workers' Compensation Commission held that the one-year statute of limitations period under the 85A statute is only a minimum that may be extended, unanimously affirming a prior judgment made by a Commission administrative law judge.

Oklahoma Statute 85A section 69(A)(1) provides that a claim shall be barred unless filed within one year of the date of the injury. The second part of that section, after the word,

"or," states that if a claimant has received benefits, the statute of limitations period is six months after the payment of a benefit.

In *Paredes v. Schlumberger Technology Group*, the Respondent argued that since the employer provided three months of benefits, the statute of limitations period ran six months later, nine months after the date of injury. The Claimant filed a Form 3 with the Commission ten months after the injury.

The administrative law judge held that the second part of the statute was meant to extend the statute period where the employer admits the claim and benefits are paid beyond one year, and that the official statute of limitations period is the greater of the two independent limitation provisions. The judge wrote, "the word 'or' is used to express alternative statutes of limitations, with claimant receiving the benefit of whichever of those is longer."

Erasmo Paredes v. Schlumberger Technology Group

Q. Is an employer protected by the exclusive remedy provision of the Oklahoma Administrative Workers' Compensation Act when a Claimant asserts a claim for benefits in another state?

A. No, In *Whited v. Parish*, the Oklahoma Supreme Court has refused to accept original jurisdiction of a Creek County case in which the district judge allowed a wrongful death action and an intentional tort against the employer to continue. The district judge ruled that the employer was not protected by the exclusive remedy provisions of the Oklahoma Administrative Workers' Compensation Act even though workers' compensation benefits were paid in Minnesota.

Justice Gurich of the Oklahoma Supreme Court, in a concurring decision, distinguished this case from *Farley v. City of Claremore*, 2020 OK 30 (mentioned above), in which the direct action against the employer was not allowed because there was an Oklahoma workers' compensation case that had been carried to conclusion.

Justice Gurich cited the case of *Whipple v. Phillips & Sons Trucking*, 2020 OK 75 (also mentioned above), in which the Court held that the parents of an unmarried employee without children could proceed in a direct action against the employer because the Administrative Workers' Compensation Act provided no benefits.

Finally, Justice Gurich opined, "[l]acking an Oklahoma workers' compensation remedy, the Creek County district court action brought by the [personal representative], is not precluded by the exclusive remedy provided by the [Administrative Workers' Compensation Act]."

Whited v. Parish, Supreme Court No.119,789.

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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. ***Does Neb. Rev. Stat. § 48-121(3) provide that an employee is entitled to receive benefits based on a loss of earning capacity when they sustain multiple injuries along the same extremity?***

A. Yes. When attempting to understand Neb. Rev. State. § 48-121, it is essential to know that the first three subdivisions of the statute address three different categories of disability and allows for various processes of determining compensation for each. Subdivision (1) addresses compensation for total disability; subdivision (2) addresses compensation for partial disability, except in cases covered by subdivision (3); and subdivision (3) lists the compensation that is to be paid for injuries to several specified parts of the body. Typically, § 48-121(1) and (2) governed a claimant's loss of earning capacity, while subdivision § 48-121(3) "provide[d] for compensation based on designated amounts for scheduled member injuries, but no loss of earning capacity." An amendment to § 48-121(3) enacted in 2007 provided that "the loss of earning capacity would be at the court's discretion where there is a loss or loss of use of more than one member which results in at least a 30-percent loss of earning capacity."

In *Espinoza*, the claimant sought an award under the 2007 amendment to § 48-121(3). She claimed that the injuries to both her hand and arm resulted in the option that the Court could consider such an award. The Court first examined the statutory analysis and definition of "member." The Court reasoned that although § 48-121(3) does not refer to the body parts listed in its first paragraph as "members," historically, the Court referred to the listed body parts as "members" or "scheduled members." Therefore, they stated that the preexisting legislation of the Supreme Court likely influenced the legislation, and § 48-121(3) should ultimately use the term in the same sense. Additionally, the first paragraph of § 48-121(3) lists specific body parts. Finally, while some dictionary definitions define "member" as a limb, other definitions broadly define the term to include parts of the body generally. For these reasons, the court found it reasonable to interpret the statute to cover a partial loss of use of multiple members.

Furthermore, the Court states that to resolve legislative ambiguity, the Court can place heavy reliance on legislative history. Referencing the 2007 amendment to § 48-121(3), the court states that no senator offered a comprehensive definition for what qualifies as "members." Therefore, this does not mean that multiple injuries to the same side do not qualify as an injury to more than one member. The Court also states that the conclusion from *Melton v. City of Holdrege* does not apply in this scenario because the claimant, in that case, sought benefits under the first paragraph of § 48-121(3), but the claimant, in this case, is seeking compensation under the third paragraph of § 48-121(3) for an award based on the loss of earning capacity.

Finally, the court reasons that "the Nebraska Workers' Compensation Act should be construed liberally to carry out its spirit and beneficent purpose of providing compensation

to employees injured on the job." For these reasons, the Nebraska Supreme Court reversed the ruling of the compensation court and remanded the case for further proceedings.

Espinoza v. Job Source USA, 984 N.W.2d 918 (Neb. 2023).

Q. ***Can a court provide meaningful appellate review when the Nebraska Workers' Compensation Court (WCC) failed to give clear directions regarding the award?***

A. No. According to Rule 11 of the Nebraska compensation court rules of procedure, compensation court orders must be sufficiently clear in addressing the parties' requested relief so that an appellate court can review the evidence relied upon by the trial judge in support of his or her findings. It requires "explicit findings of fact and conclusions of law so that all interested parties and a reviewing court can determine the legal and factual basis upon which a decision is made."

In *Lewis*, Employee, Allen Lewis, had to have his left leg amputated after a work accident where an autopaving machine rolled over his leg. Lewis sought modifications to his work-provided housing so he could move about his home in a wheelchair. The WCC concluded that modifications should be done to the existing home, but, if necessary, a new home could be built for Lewis. Employer appealed.

The Nebraska Supreme Court held that the compensation court's failure to clearly direct the parties' future action precludes meaningful appellate review. The court vacated the order and remanded the case with directions to enter an order complying with the requirements of Rule 11 of the compensation court rules of procedure. Rule 11 states that "decisions of the court shall provide the basis for a meaningful appellate review." Rule 11 ensures that compensation court orders are sufficiently clear in addressing the parties' requested relief so that an appellate court can review the evidence relied upon by the trial judge in support of his or her findings. They concluded that in this case, the order was confusing, and the undertakings of each party were unclear. Thus, the case was remanded.

Lewis v. MBC Constr. Co., 962 N.W.2d 359 (Neb. 2021).

Q. ***Can a motion to compel Employer to pay for Employee's medical treatment be reviewed by an appellate court if not all issues have been decided?***

A. No. According to *Jacobitz v. Aurora Co-op*, when multiple issues are presented to a trial court for simultaneous disposition in the same proceeding and the court decides some of the issues, while reserving other issues for later determination, the court's determination of fewer than all the issues is an interlocutory order and is not a final order for the purpose of an appeal. 841 N.W.2d 377 (2013).

In *Howell*, Employee, Chanin Howell, suffered a work-related injury while working as a bus driver for Transit Authority for the City of Omaha. She filed with the WCC and made a motion to compel payment for certain medical treatment, which was granted. Employer appealed.

The Court of Appeals of Nebraska cited *Jacobitz*, where the Nebraska Supreme Court held that "permitting employers to appeal from an adverse ruling **before** the Workers'

Compensation Court has determined benefits is inconsistent with the Legislature's intent to provide prompt benefits to injured workers." Accordingly, the appellate court here ruled that the WCC's order ruling on Howell's motion to compel was not a final determination of benefits as the court "reserved the issue of permanent benefits until after the provision of vocational rehabilitation benefits." Thus, since some issues were still reserved for determination at the time of the motion to compel, Employer cannot appeal the case since it was not a final order.

Howell v. Transit Auth. of City of Omaha, No. A-21-023, 2022 WL 151379 (Neb. Ct. App. Jan. 18, 2022)

Q. *Is an employee entitled to temporary total disability (TTD) benefits when the employee had still been receiving regular pay?*

A. No. According to *Anderson v. Cowger*, if wages paid are intended to be in lieu of compensation, credit for the wages is allowed. 65 N.W.2d 51 (Neb. 1954). Here, Employee received her regular wage when she was not at work due to the workplace injury, thus, Employer is entitled to credits for payments made and does not have to pay extra TTD benefits.

In *Simpson*, Employee, Lynne Simpson, was hit on the head by a steel tray when working as a special education paraeducator. Simpson sought, among other things, additional TTD benefits on days where she could not work due to doctor's appointments. The WCC held that Simpson was not entitled to any additional TTD benefits because Simpson received her regular wages in lieu of compensation on the additional dates requested.

The Court of Appeals of Nebraska affirmed this decision, citing *Anderson v. Cowger*. There, the court held that "if an employee is paid his or her regular wage although he or she does no work at all, it is a reasonable inference that the allowance is in lieu of compensation." Simpson received her regular wage when she was not at work due to the workplace injury and was not forced to use accrued vacation time or sick time to visit the doctor. Thus, the appellate court found that Employer was entitled to credit for the payments made to Simpson as her regular wages in lieu of workers' compensation benefits. The court found that the WCC's determination that Simpson is not entitled to any additional TTD benefits was not clearly erroneous.

Simpson v. Lincoln Pub. Sch., 971 N.W.2d 347 (Neb. Ct. App. Jan. 25, 2022).

Q. *Does the Nebraska Workers' Compensation Court (WCC) have statutory authority to modify an award to grant additional rehabilitative services?*

A. Yes. According to Neb. Rev. Stat. § 48-162.01(7), the WCC has the statutory authority to modify the original award in order to accomplish the goal of restoring the injured employee to gainful and suitable employment.

In *Spratt*, Employee, James Spratt, obtained an award granting medical rehabilitation services for his lumbar back. Six weeks after the issuance, Claimant's treating physician sought permission to treat his thoracic back pain. The physician opined that the original lumbar back pain was "generated" from Claimant's thoracic back. Employer denied treatment, and the Nebraska WCC denied the request for modification.

The Nebraska Supreme Court explains that in 1969, the Legislature first expressed a goal, as the section now reads, “One of the primary purposes of the Nebraska Workers’ Compensation Act is restoration of the injured employee to gainful employment.” From then on, the power to modify remained codified in subsection (7). Thus, the WCC erred in its conclusion that it lacked the power to modify the original award to treat Spratt's thoracic back. The Nebraska Supreme Court emphasized that nothing in the opinion should be read to “suggest how the compensation court should exercise its power pursuant to § 48-162.01(7), or to limit or preclude the court in making findings of fact.” Thus, the Court concluded that the WCC had authority pursuant to § 48-162.01(7) to modify the original award.

Spratt v. Crete Carrier Corp., 971 N.W.2d 335 (Neb. 2022).

Q. ***Can the Nebraska Workers Compensation Court (WCC) find a claimant to be permanently disabled before all injuries have reached maximum medical improvement?***

A. No. The Nebraska Court of Appeals held that the determination of permanent partial disability is premature when not all injuries resulting from the accident have reached maximum medical improvement.

In *Copley*, Employee, Winfield Scott Copley, was operating a forklift when it tipped forward and Copley was thrown into the “roll cage” where he struck the left side of his face and left shoulder. He received medical treatment for his left eye and shoulder, and he was eventually released at Maximum Medical Improvement (MMI) for his left shoulder. The WCC awarded Copley permanent partial disability for his shoulder and ordered continuing temporary total disability payments for his left eye. The WCC also held that Copley was permanently disabled due to his shoulder injury.

Addressing the WCC’s finding of permanent disability, the appellate court reasoned that it was entirely possible that Copley's eye injury may affect his ability to work before it ever reaches MMI. However, the court states, “Such a factual scenario is precisely the reason that permanent impairment and, thus, permanent disability, should not be determined until all of the claimant's injuries have reached maximum medical improvement.” Accordingly, the appellate court held that the WCC finding of permanent disability due to Claimant’s shoulder was premature.

Copley v. Advanced Servs., Inc., No. A-21-209, 2022 WL 598761 (Neb. Ct. App. Mar. 1, 2022).

Q. ***Is an individual considered an employee of a company when the lease agreement for work equipment gives the company exclusive control, possession, and supervision?***

A. No. Control, possession, and supervision language is required to be in every lease agreement for equipment. This language itself does not show the degree of control a company exercised over the method and manner of performing the work.

In *Cajiao*, Oscar Cajiao was injured in a motor vehicle accident while driving a semi-trailer tractor leased by Employer, Arga Transport. Cajiao maintained that he was an employee of the company and entitled to workers' compensation. The Nebraska Workers' Compensation Court (WCC) held that Cajiao was an independent contractor, and Cajiao appealed.

The Court of Appeals of Nebraska affirmed the holding of the WCC. The court disagreed with Cajiao's argument that the language in the lease agreement shows that Arga Transport maintained control over his work. The appellate court explained that "the exclusive control, possession, and supervision provision is required to be in every lease that an authorized carrier enters into for equipment." Although Arga may have exercised control over the result of the work, the court found that Arga did not exercise control over the actual operation of the truck or the manner in which Cajiao completed the delivery. Thus, the Court of Appeals affirmed the decision of the WCC that Cajiao is an independent contractor and therefore not entitled to workers' compensation benefits.

Cajiao v. Arga Transp., Inc., 972 N.W.2d 433 (Neb. Ct. App. Mar. 1, 2022).

Q. Is an Employee entitled to vocational rehabilitation if they have not suffered permanent medical impairment?

A. No. Pursuant to *Green v. Drivers Management Incorporated*, "Without a finding of permanent medical impairment, there can be no permanent restrictions. Without impairment or restrictions, there can be no disability or labor market access loss." 639 N.W.2d 94 (Neb. 2002). If one is able to return to work, he or she is not entitled to vocational rehabilitation.

In *Serna*, Employee, Maria Ronquillo Serna was injured while performing work duties and filed for workers' compensation. The Nebraska Workers' Compensation Court (WCC) held that she had many pre-existing issues and that Serna's injuries did not make her permanently disabled. Accordingly, the WCC found that she was not entitled to permanent disability benefits, future medical benefits, or vocational rehabilitation. Serna appealed.

The Court of Appeals of Nebraska affirmed the decision of the WCC. The appellate court cites *Green v. Drivers Management Incorporated* stating, "Without a finding of permanent medical impairment, there can be no permanent restrictions. Without impairment or restrictions, there can be no disability or labor market access loss." The appellate court finds credible the opinion of a physician who states that Serna suffered no permanent impairment as a result of the work injury. Thus, because the WCC found the impairment not attributable to Serna's injury and that she was not entitled to an award of permanency, Serna is not entitled to vocational rehabilitation.

Serna v. Advance Servs. Inc., No. A-21-811, 2022 WL 1634265 (Neb. Ct. App. May 24, 2022).

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).

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KEEPING YOUR WORK COMP CASE FROM BEING LITIGATED

I. Why might an injured employee choose to litigate?

Certain factors increase the likelihood an injured employee may litigate their workers' compensation claim.

- A lack of understanding of the work comp process
- Untimely communication regarding their case
- Fear of getting fired because of their injury
- Dissatisfaction with the medical service they were sent to for treatment
- A poor relationship between the employee and employer

II. Understanding The Employee & Injury

The workers' compensation process can be overwhelming for all parties involved. Simply taking the time to learn about your employee can go a long way in easing anxiety and tension associated with the process.

- Learn about the employee's background
- Listen to the employee's concerns
- Communicate with empathy
- Don't be defensive

A. Communication

Clear and timely communication can be very helpful in preventing the litigation of workers' compensation claims. Communication reassures injured employees that their concerns are being heard, which in turn may lessen the likelihood they will pursue litigation.

- Reach out post-injury to check in. Review the workers compensation process with the employee and remind them that their healing is important to you. This is most beneficial if done in the first 24 to 48 hours following the accident.
- Provide an injury packet to employees post-accident. This provides another chance to review the workers compensation process and address misconceptions.
- Be available to answer questions. This helps to prevent misunderstanding by employees, such as mistakenly thinking their claim has been denied.

B. Treating the Injury

- Investigate the claim quickly and thoroughly to determine if it is compensable.
- Work with a reliable, reputable medical provider to move the medical treatment along quickly and effectively.
- Timely authorize appropriate treatment to avoid delaying the employee's progress.
- Offer transitional or modified work for injured employees.

III. Modified & Transitional Work

Offering a return-to-work program that includes transitional or modified work encourages a safer and more comfortable return for the injured employee. Employees who feel positively about their return are less likely to choose to litigate their claim.

- Transitional work should be available when an employer is unable to accommodate an employee's restrictions.
- Modified work should be made available by employers who are able to accommodate work restrictions.

A. Training

Training supervisors and managers on how to handle work comp cases is crucial in preventing litigation. Training should focus on the interactions between supervisors and injured employees to prevent misunderstanding and frustration by both parties.

- Employers should consider training supervisors on the following topics:
  - The step-by-step process of a work comp claim, including internal and external processing.
  - Empathetic communication with injured employees regarding timeline, job security, documentation, and entitlement to benefits.
  - Work restrictions and modifications.

B. Pro Se Employees

- If the employee remains pro se, typically the case can be settled more quickly and for less money than if the employee hires an attorney and files a formal claim for compensation or application for benefits.
  - Timely and consistent TTD payments, payment of mileage benefits, direction of medical treatment, and communication with the employee are all frequently cited factors by claimants' attorneys as to issues that bring claimants to their offices to file formal claims.
- Once the employee reaches MMI, if appropriate, request a disability rating from the treating physician right away. Some jurisdictions require a rating to obtain approval of a pro se settlement. A disability rating can help negotiations with both pro se employees and represented employees. It may not be necessary on minor strain or contusion cases.
- Once you have the disability rating, make a good faith offer to the employee to resolve the case. Discuss the rationale behind your offer (good result from surgery, full strength, full range of motion, etc.).
- Once an agreement has been reached, refer to counsel as quickly as possible so a settlement conference can be set.
  - In some jurisdictions, we can request a walk-in settlement conference, which typically will get the settlement conference set even faster.

C. Considerations for Represented Employee

Once an employee hires an attorney, the case can still be settled quickly.

- Early communication with claimant's counsel: Advise claimant's counsel of your desire to settle the case without ratings. Forward all medical records as soon as received from the provider and request a settlement demand.
- Make an offer: It is not necessary to wait for the claimant's attorney to make a demand. Making a good faith offer early in the case can move the case to settlement more quickly.
- Avoid the IME: A good faith opening offer can keep the claimant's attorney from obtaining their own IME. A claimants' IME can delay settlement if the IME physician takes a long time to complete the report, or worse, if the IME physician recommends additional treatment.
- Discuss any potential issues that could lead to a delay in resolving the case early with opposing counsel.
    - Examples: low PPD rate, TTD overpayment, prior accidents. These are all issues that if a claimants' attorney is not aware of at the onset of the case, it can delay negotiations. Claimants' attorneys often have to manage the claimant's expectations, which can often be unrealistic. Raising these issues with opposing counsel early can help opposing counsel manage any unrealistic expectations.
- Get input from the judge or arbitrator where appropriate.
    - We can get the judge or arbitrator to weigh in at a formal setting or informally if the parties agree. If the parties are at an impasse, a recommendation from a judge or arbitrator can help move the matter forward much more quickly than waiting for a formal hearing on the issue.

IV. SETTLING THE CASE: WHEN AND HOW

A. Settlement vs. Litigation

- Determine early on if the case is one you want to try and settle or push to a final hearing. If the decision is made to litigate the case:
    - Explore any potential ways to resolve the dispute and settle if possible.
        - Example: If it is a denied case, and there is a third-party lawsuit involved for the injury, it may be possible to resolve an otherwise disputed claim by waiving any subrogation interest.
    - Try and learn from opposing counsel what the claimant's concerns are with resolving the case, if applicable.
    - Set the employee's deposition, if necessary, early on in the litigation process to begin the process of gathering any prior treatment records or conducting further discovery.
    - Proceed with obtaining any IMEs and deposing those experts to ensure admissibility of any and all reports.

- Proceed with a mediation: some jurisdictions require a mediation before a request for hearing can be made.
- Make a cost of defense offer to try and resolve short of a final hearing.
- Educate claimant's counsel on the effect of an award on social security disability benefits, if applicable.

B. Settlement Negotiation Strategies to Move Cases Quickly and Efficiently

- Look for indications from claimant's counsel that a case can be resolved quickly, even if the claimant has not yet reached MMI. Examples of this include:
  - Hesitation from the employee in proceeding with medical treatment: If the employee is requesting additional time to consider whether or not to proceed with an authorized medical procedure, it may indicate that they would be open to settling the case, even if they are not at MMI. A good faith offer with some consideration for additional medical treatment can often get such cases resolved before the employee has reached MMI.
  - Dissatisfaction with the treating physician: If an employee expresses that he or she does not like the chosen treating physician, a good faith offer with some consideration for additional medical treatment with the suggestion that the employee can use that money to treat wherever he or she would like may be able to resolve the case quickly.
  - Depositions: If the claimant's counsel sets a deposition or indicates he or she is going to set a deposition, it may be a good time to make an offer, so they can have the opportunity to save on the cost of the deposition.
- Provide Defense counsel with sufficient authority at the beginning of negotiations.
  - Defense counsel should always try and resolve the case for as little as possible. However, not having to go back and forth for additional authority can make the negotiations run more smoothly and much more quickly.
  - Set a target outcome amount with defense counsel and provide that authority. Defense counsel can than speak more openly and candidly with opposing counsel about where the defense is valuing the case to try and resolve the case more quickly.
- Set a time limit for opposing counsel to respond to a settlement offer when appropriate.
  - Follow up frequently with opposing counsel once an offer has been made. If there is a significant delay in getting a response from opposing counsel, advise opposing counsel that we will be pushing for a dismissal for failure to prosecute.
  - Continue to point out the strength of your case and the weaknesses of your opponent's case during negotiations. Just because you may not believe your defense will prevail at trial does not mean you should discard it during negotiations.

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SUBROGATION IN KANSAS & MISSOURI WORKERS' COMPENSATION

I. SUBROGATION

The substitution of one person in the place of another with reference to a lawful claim, demand, or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights, remedies.

II. EXAMPLES IN WORKERS' COMPENSATION

If an employee suffers a work-related injury which gives rise to a common law claim for damages against anyone other than the employer. For example:

A. Injuries caused by machines
   i. Manufacturer
   ii. Supplier
   iii. Refurbisher
   iv. Maintenance Company
   v. Testing/inspection company

B. Automobile Accidents

C. Premises Liability Claims
   i. At the employer's premises
      a. Co-employees
      b. Contractors
   ii. Away from the employers premises
      a. Owner/Operator of premises

III. HOW IT WORKS

A. **Intervention** - Can the employer intervene into an action filed by the employee?

B. **Direct Action** - Does the employer have the right to file its own action to recover?

C. **Notice** - Is the employee required to give the employer notice of a third-party action?

D. **Settlement/Release** - Can the employee resolve the third-party claim without the employer?

IV. CALCULATION OF RECOVERY

A. What counts toward the lien?

i. Disability benefits
ii. Death benefits
iii. Medical expenses
iv. Medical management expenses
v. Medicare set asides
vi. Claims handling expenses
vii. Legal fee

B. What does the lien apply toward?

i. UM/UIM
ii. medical malpractice
iii. legal malpractice
iv. loss of consortium
v. wrongful death

C. Formula applied to third party recovery

D. Future Credit

V. EVALUATION OF THIRD-PARTY CLAIMS

A. Comparative Fault

i. **Kansas** - The contributory negligence of any party in a civil action shall not bar such party or such party's legal representatives from recovering damages for negligence resulting in death, personal injury, property damage or economic loss, if such party's negligence was less than the causal negligence of the party or parties against whom claim for recovery is made, but the award of damages to any party in such action shall be diminished in proportion to the amount of negligence attributed to such party. If any such party is claiming damages for a decedent's wrongful death, the negligence of the decedent, if any, shall be imputed to such party. K.S.A. 60-258a

ii. **Missouri** - The Missouri Supreme Court adopted a system of pure comparative fault for negligence cases. Gustafson v. Benda, 661 S.W.2d 11 (Mo.banc 1983). "Pure" comparative fault refers to the concept set forth in the Uniform Comparative Fault Act (UCFA) § 1(a) which states that a plaintiff in a tort action based on fault may recover in accordance with the apportionment of fault among all parties. Under Missouri's pure comparative fault approach, plaintiffs may still recover some damages even if they are 99% at fault in the transaction at issue.

B. Statute of Limitations

i. Kansas

- Personal injury 2 years KSA §60-513(a)(4)

ii. Missouri

- Personal injury 5 years RSMo 516.120

iii. Statutory Employer Bar

- If the third-party tortfeasor can argue it was a statutory employer of the injured employee, the claim may be barred by immunity and the exclusive remedy under the workers' compensation act.

iv. Co-Employee Bar

- Most states will not allow a third-party recovery against co-employees. Missouri, however, no longer prohibits actions against co-employees under the immunity provision of the Missouri Act.

VI. INVESTIGATION AND PRESERVATION OF EVIDENCE

A. Identification of causes

B. Identification of potential defendants

C. Interviews of witnesses

D. Preservation of evidence

i. Photographs

ii. Business records

iii. Witness identities

iv. Machinery

VII. SUBROGATION STATUES: KANSAS AND MISSOURI

A. KANSAS

K.S.A. §44-504

Remedy against negligent third party; employer and workers compensation fund subrogated, exclusion; credits against future payments; limitation of actions; attorney fees.

When the injury or death for which compensation is payable under the workers compensation act was caused under circumstances creating a legal liability against some person other than the employer or any person in the same employ to pay damages, the injured worker or the worker's dependents or personal representatives shall have the right

to take compensation under the workers' compensation act and pursue a remedy by proper action in a court of competent jurisdiction against such other person.

In the event of recovery from such other person by the injured worker or the dependents or personal representatives of a deceased worker by judgment, settlement or otherwise, the employer shall be subrogated to the extent of the compensation and medical aid provided by the employer to the date of such recovery and shall have a lien thereof against the entire amount of such recovery, excluding any recovery, or portion thereof, determined by a court to be loss of consortium or loss of services to a spouse. The employer shall receive notice of the action, have a right to intervene and may participate in the action. The district court shall determine the extent of participation of the intervener, including the apportionment of costs and fees. Whenever any judgment in any such action, settlement or recovery otherwise is recovered by the injured worker or the worker's dependents or personal representative prior to the completion of compensation or medical aid payments, the amount of such judgment, settlement or recovery otherwise actually paid and recovered which is in excess of the amount of compensation and medical aid paid to the date of recovery of such judgment, settlement or recovery otherwise shall be credited against future payments of the compensation or medical aid. Such action against the other party, if prosecuted by the worker, must be instituted within one year from the date of the injury and, if prosecuted by the dependents or personal representatives of a deceased worker, must be instituted within 18 months from the date of such injury.

Failure on the part of the injured worker, or the dependents or personal representatives of a deceased worker to bring such action within the time specified by this section, shall operate as an assignment to the employer of any cause of action in tort which the worker or the dependents or personal representatives of a deceased worker any have against any other party for such injury or death, and such employer may enforce the cause of action in the employer's name or in the name of the worker, dependents or personal representatives for their benefit as their interest may appear by proper action in any court of competent jurisdiction. The court shall fix the attorney fees which shall be paid proportionately by the employer and employee in the amounts determined by the court.

If the negligence of the worker's employer or those for whom the employer is responsible, other than the injured worker, is found to have contributed to the party's injury, the employer's subrogation interest of credits against future payments of compensation and medical aid, as provided by this section, shall be diminished by the percentage of the recovery attributed to the negligence of the employer or those for whom the employer is responsible, other than the injured worker.

In any case under the workers compensation act in which the workers compensation fund has paid or is paying compensation, the workers compensation fund is herby subrogated to the rights of the employer under this section and shall have all the rights of subrogation

or to credits against future compensation payments which are granted to the employer by this section. The commissioner of insurance may exercise all such rights for the fund to the same extent that such rights may be exercised by the employer under this section, including the right to intervene, to enforce a lien or to bring any cause of action, all as provided in this section.

As used in this section, “compensation and medical aid” includes all payments of medical compensation, disability compensation, death compensation, including payments under K.S.A. 44-570 and amendments thereof, and any other payments made or provided pursuant to the workers compensation act.

In any case under the workers compensation act in which the workers compensation fund or an insurer or a qualified group-funded workers compensation pool, as provided in K.S.A. 44-532 and amendments thereto, is subrogated to the rights of the employer under the workers compensation act, the court shall fix the attorney fees which shall be paid proportionately by the workers compensation fund, insurer or qualified group-funded workers compensation pool and the worker or such worker's dependents or personal representatives in the amounts determined by the court based upon the amounts to be received from any recovery pursuant to an action brought under this section.

B. MISSOURI

RSMO § 287.150

Where a third person is liable to the employee or to the dependents, for the injury or death, the employer shall be subrogated to the right of the employee or to the dependents against such third person, and the recovery by such employer shall not be limited to the amount payable as compensation to such employee or dependents, but such employer may recover any amount which such employee or his dependents would have been entitled to recover. Any recovery by the employer against such third person shall be apportioned between the employer and employee or his dependents using the provisions of subsections 2 and 3 of this section.

When a third person is liable for the death of an employee and compensation is paid or payable under this chapter, and recovery is had by a dependent under this chapter either by judgment or settlement for the wrongful death of the employee, the employer shall have a subrogation lien on any recovery and shall receive or have credit for sums paid or payable under this chapter to any of the dependents of the deceased employee to the extent of the settlement or recovery by such dependents for the wrongful death. Recovery by the employer and credit for future installments shall be computed using the provisions of subsection 3 of this section relating to comparative fault of the employee.

Whenever recovery against the third person is affected by the employee or his dependents, the employer shall pay from his share of the recovery a proportionate share of the expenses of the recovery, including a reasonable attorney fee. After the expenses

and attorney fee have been paid, the balance of the recovery shall be apportioned between the employer and the employee or his dependents in the same ratio that the amount due the employer bears to the total amount recovered if there is no finding of comparative fault on the part of the employee, or the total damages determined by the trier of fact if there is a finding of comparative fault on the part of the employee. Notwithstanding the foregoing provision, the balance of the recovery may be divided between the employer and the employee or his dependents as they may otherwise agree. Any part of the recovery found to be due to the employer, the employee or his dependents shall be paid forthwith and any part of the recovery paid to the employee or his dependents under this section shall be treated by them as an advance payment by the employer on account of any future installments of compensation in the following manner:

1. The total amount paid to the employee or his dependents shall be treated as an advance payment if there is no finding of comparative fault on the part of the employee; or
2. A percentage of the amount paid to the employee or his dependents equal to the percentage of fault assessed to the third person from whom recovery is made shall be treated as an advance payment if there is a finding of comparative fault on the part of the employee.

In any case in which an injured employee has been paid benefits from the second injury fund as provided in subsection 3 of section 287.141, and recovery is had against the third party liable to the employee for the injury, the second injury fund shall be subrogated to the rights of the employee against said third party to the extent of the payments made to him from such fund, subject to provisions of subsections 2 and 3 of this section.

No construction design professional who is retained to perform professional services on a construction project or any employee of a construction design professional who is assisting or representing the construction design professional in the performance of professional services on the site of the construction project shall be liable for any injury resulting from the employer's failure to comply with safety standards on a construction project for which compensation is recoverable under the workers' compensation law, unless responsibility for safety practices is specifically assumed by contract. The immunity provided by this subsection to any construction design professional shall not apply to the negligent preparation of design plans or specifications.

Any provision in any contract or subcontract, where one party is an employer in the construction group of code classifications, which purports to waive subrogation rights provided under this section in anticipation of a future injury or death is hereby declared against public policy and void. Each contract of insurance for workers' compensation shall require the insurer to diligently pursue all subrogation rights of the employer and shall require the employer to fully cooperate with the insurer in pursuing such recoveries, except that the employer may enter into compromise agreements with an insurer in lieu

of the insurer pursuing subrogation against another party. The amount of any subrogation recovery by an insurer shall be credited against the amount of the actual paid losses in the determination of such employer's experience modification factor within forty-five days of the collection of such amount.

Notwithstanding any other provision of this section, when a third person or party is liable to the employee, to the dependents of an employee, or to any person eligible to sue for the employee's1 wrongful death as provided in section 537.080 in a case where the employee suffers or suffered from an occupational disease due to toxic exposure and the employee, dependents, or persons eligible to sue for wrongful death are compensated under this chapter, in no case shall the employer then be subrogated to the rights of an employee, dependents, or persons eligible to sue for wrongful death against such third person or party when the occupational disease due to toxic exposure arose from the employee's work for employer.

VIII. SUBROGATION CASE LAW: KANSAS AND MISSOURI

A. KANSAS

1. *Turner v. Pleasant Acres LLC*, 2022 WL 815834 (Kan. App. 2022)

   The Kansas Court of Appeals addressed the issue of whether the Board erred in concluding that the Fund is not entitled to a right of subrogation and lien under K.S.A. 44-504. Here, employee was involved in an accident on December 12, 2016 in Kiowa County while driving on Highway 54 on his way to Bucklin. According to employee, a vehicle heading eastbound crossed the center line and struck the tractor-trailer he was driving head-on. As a result of the accident, the driver of the other vehicle was pronounced dead. Employee was evaluated by paramedics for injuries at the scene of the accident and went to the emergency room at Great Bend Regional Hospital the next day. Employee also brought suit in federal court against Continental Western Insurance Company, the carrier of the uninsured motorist coverage for employee’s truck.

   The parties to the federal lawsuit executed a “Settlement Agreement and Release” on December 17, 2018. The settlement provides that in exchange for the payment of $230,000 by Continental Western Insurance Company, employee agreed to release all claims arising out of the injuries, damages, and losses sustained by him in the accident. The claims released included—among other things—“all past, present and future damages or benefits for wage loss benefits, essential services, medical bills or benefits, rehabilitation benefits, counseling, pain and suffering, emotional distress, permanent impairment or disfigurement, and any and all other damages” arising out of the accident.

The Court of Appeals found that the Fund had a subrogation lien against any duplicative recovery employee received in his federal lawsuit against the uninsured motorist carrier arising out of the same work-related accident that is the subject of this workers compensation action. However, did not extend entitlement to a subrogation lien on any portion of the recovery that is found to have been paid for loss of consortium or loss of services to employee's spouse.

In sum, uninsured motorist coverage and underinsured motorist coverage settlements can now be used to satisfy liens in Kansas Workers' Compensation.

2. *PMA Group v. Trotter,* 281 Kan. 1344 (2006)

The Supreme Court addressed the issue of whether an employer had a subrogation lien against the amount recovered by a worker from a coworker's insurer who failed to assert the exclusive remedy of worker's compensation as a defense. Claimant was injured when she was struck by a car driven by her coworker in their employer's parking lot. Claimant accepted worker's compensation benefits from her employer and its insurer. She subsequently entered into a settlement agreement with her coworker's insurer after the insurer failed to assert the worker's compensation defense. The Court held that an employer cannot assert a subrogation lien against an amount recovered by an employee from a coworker, because K.S.A. 44-504 is inapplicable to such a situation.

3. *Jerby v. Truck Insurance Exchange*, 36 Kan. App. 2d 199 (2006)

The Court of Appeals addressed, for the first time, whether recoveries are duplicative when the nature of the damages in a workers' compensation case and tort settlement are the same, but the amount recovered in the tort settlement does not fully compensate claimants for their loss. Here, employee died as a result of injuries sustained in a work-related automobile accident. His heirs brought suit against the other driver's insurance carrier, who settled the claim for the policy limits. It was unknown at the time of this suit whether the settlement was conditioned upon the release of the other driver personally.

The respondent employer asserted its subrogation rights against the settlement under K.S.A. 44-504, which lead to this action. Claimants contend that the settlement was not duplicative of the workers' compensation benefits paid by the employer because the settlement did not exceed the amount of actual lost wages. In *Jerby*, Alan Jerby died following a collision with a third-party who had only $100,000 in third-party liability coverage. Despite suffering a loss of more than $350,000 in lost wages, Jerby's family settled for the $100,000 limits, and then sued the workers' compensation carrier for a declaratory judgment that the carrier

should not be entitled to a future credit because the third-party settlement did not exceed the $350,000 lost wage damages.

In construing the relevant statute, the Court of Appeals compared it to the Kansas Automobile Injury Reparations Act and relied on decisions under that Act to reach its holding. The Court found that the answer turned on whether claimants had preserved their claim against the other driver individually. If they had, settlement proceeds are not duplicative inasmuch as the widow's share attributable to workers' compensation-related losses exceeded the amount of the respondent's lien at the time. But, if the claimants released their claim against the other driver, respondent was entitled to reimbursement for workers' compensation benefits paid, to the extent of duplicative benefits. The trial court concluded that the American Family settlement was not duplicative of the workers' compensation benefits paid by Truck Ins. Exchange because the settlement did not exceed the amount of Jerby's actual lost wages.

4. *Richard v. Liberty Mutual Ins. Co.*, 2007 WL 1747886 (Kan. Ct. App. June 15, 2007) (unpublished).

   Though unpublished, this case helped clarify the law on efforts to circumvent and avoid repayment of carriers' workers' compensation liens.

   This case affirmed the principle set forth in *McGranaham v. McGough*, 802 P.2d 593 (Kan. Ct. App. 1990), aff'd in part, rev'd in part, 820 P.2d 403 (Kan. 1991), that employers subrogation liens only extend to the portion of a worker's recovery which duplicates the compensation and medical expenses paid by the employer under the Workers' Compensation Act.

   Plaintiffs' counsel may try to gerrymander settlements and releases in such a way as to disguise third party settlements as compensation for items of damage not duplicative of the workers' compensation lien. Obviously, they do this to avoid repayment of the lien. However, the court held such efforts must be supported by the evidence, or the attorney making such a claim in an effort to avoid the lien may be subject to sanctions.

   A statement that an award is not duplicative must be supported by substantial competent evidence. If there is "substantial competent evidence" that a plaintiff's attorney had no basis to support his claim that the settlement is not duplicative, the court is justified in awarding sanctions against him. This amount may include the carrier's attorney's fees incurred in defending the spurious "non-duplicative" gerrymandering argument asserted by the plaintiff.

A workers' compensation carrier is not entitled to reimbursement from a settlement between a third party and a worker's surviving spouse and children when:

a. They entered into a partial settlement with the third party,

b. Reserved the right to preserve their claims against the third party for the balance of their loss, AND

c. The spouse's share of the settlement regarding damages compensable under the workers' compensation law exceeded the workers' compensation lien at the time.

The decision recognizes that if a plaintiff's attorney attempts and fails to gerrymander a settlement he may not be entitled to an attorney fee out of the workers' compensation lien. The Richard court focused on the language of K.S.A. 44-504. The attorney's fees mandated in Section 44-504(b), (c) and (g) are designed to compensate a plaintiff's lawyer who recovers an award which is subrogated to the employer's insurer.1 However, as noted by the court in Richard, the one-third fee to the plaintiff's attorney is not automatic. If the one-third fee is excessive due to the ease of obtaining the settlement or the amount of services provided, then the court may award a lesser fee. Additionally, where the plaintiff's attorney attempts to gerrymander the settlement or hide a settlement from the carrier so as to defeat the lien, no attorney's fee should be awarded.

The trial court should use the reasonableness standard in awarding attorney's fees. When considering the reasonableness of attorney's fees, the trial court should consider "the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly." Id.; K.R.P.C. Section 1.5(a). The trial court has wide discretion in awarding attorney's fees; however, the amount of the fees must be supported by substantial competent evidence and a hearing may be necessary.

5. *State Farm Mutual Ins. Co. v. Kroeker*, 676 P.2d 66 (Kan. 1984).

In *Kroeker*, the Kansas Supreme Court found that settlement proceeds are not duplicative of the workers' compensation benefits received if the widow's share, which relates to damages compensable under workers' compensation law exceeded the amount of the carrier's lien at the time. On the other hand, if the widow and the children settled their entire claim against the third party and released him, then the workers' compensation carrier is entitled to reimbursement to the extent of any duplicative benefits.

In *Kroeker*, the issue was the insurer's right to PIP reimbursement when its insured made a partial settlement of claims against tortfeasor's estate but

reserved the right to proceed against the estate for the balance of the claim. The Supreme Court distinguished these facts from those in Russell v. Mackey, 592 P.2d 902 (Kan. 1979). It held that when there is a partial settlement of a claim and the settlement exceeds the PIP benefits paid, the proceeds of the partial settlement are not duplicative of the PIP benefits paid. However, "if the injured insured settles his total claim with the tortfeasor and releases the tortfeasor from all further liability, the recovery is duplicative as a matter of law, and the PIP carrier has a lien and is entitled to reimbursement for the total amount of PIP benefits paid out of the recovery made by the insured, subject to the two statutory exceptions provided for in sections (d) and (e) of K.S.A. Section 40-3113(a)."

6. *Nordstrom v. City of Topeka*, 613 P.2d 1371 (Kan. 1980); *Anderson v. National Carriers, Inc.*, 717 P.2d 1068 (Kan. App. 1986), aff'd, 727 P.2d 899 (Kan. 1986); *Lemry v. Buffalo Airways, Inc.*, 789 P.2d 1176 (Kan. App. 1990); *Leroy v. City of Coffeyville*, 671 F. Supp. 23 (D. Kan. 1987).

   The apportioning of attorneys' fees applies to both actions brought by the employee and the employer. Where an attorney for the employee brings an action and recovers the carrier's lien, the employee's attorney is entitled to an attorney's fee fixed by the court. *Nordstrom v. City of Topeka*, 613 P.2d 1371 (Kan. 1980).

   It is an abuse of discretion to enter an order that divides the payment of attorneys' fees proportionally between the worker and the employer when the worker's recovery also included the employer's subrogation lien recovery. *Anderson v. National Carriers, Inc.*, 717 P.2d 1068 (Kan. App. 1986), aff'd, 727 P.2d 899 (Kan. 1986).

   The proportion of attorneys' fees to be paid by the carrier shall be calculated based on the carrier's total potential liability and not on past benefits actually paid by the carrier. *Lemry v. Buffalo Airways, Inc.*, 789 P.2d 1176 (Kan. App. 1990), rev. denied.

   Attorneys' fees are not allowed for the workers' compensation carrier's counsel from the third party recovery, but are allowed for the worker's attorney. However, the degree of participation by the carrier's counsel is taken into consideration in determining the percentage of fees to be paid to the worker's attorney. *Leroy v. City of Coffeyville*, 671 F. Supp. 23 (D. Kan. 1987).

   If the insurer is not subrogated, the plaintiff's attorney is not entitled to attorneys' fees. *Deffenbaugh Indus., Inc. v. Wilcox*, 11 P.3d 98 (2000), rev. denied, 270 Kan. 897 (Kan. 2001). The statute rewards an attorney who does work, even inadvertently, for the insurer.

7. *McGranaham v. McGough*, 802 P.2d 593 (Kan. App. 1990), aff'd in part, rev'd in part, 820 P.2d 403 (Kan. 1991)

   The Kansas Court of Appeals in *McGranaham v. McGough* held that all elements of personal injury damages, including medical expenses, lost wages, disability compensation, pain and suffering, and loss of services, are subject to workers' compensation carrier's rights of subrogation. Damages recovered in a third party action for loss of services and loss of consortium are not subject to the workers' compensation carrier's lien because they are not compensable under the Workers' Compensation Act.

   After the carrier in *McGranaham* paid $12,616.29 in compensation benefits to the employee, the employee settled his third party action for $10,000. The plaintiff tried to allocate portions of the settlement to avoid the workers' compensation lien. The stipulated settlement provided that $6,000 was for pain and suffering, $3,000 for his wife's loss of consortium, and $1,000 was for future medical expenses, and nothing was allocated to past medical expenses or lost wages.

   The court agreed with the plaintiff that the carrier was not entitled to the $3,000 for the wife's loss of consortium claim because the amount did not represent a duplicative payment made by the carrier. The court, however, held that the carrier was subrogated to the $7,000, including the $6,000 in pain and suffering, because pain and suffering is an integral part of the calculation of disability.

   The central holding is that subrogation was not allowed where the third party does not duplicate the compensation in medical benefits paid by the workers' compensation carrier.

8. *Copeland v. Toyota Motor Sales U.S.A.*, Inc., 136 F. 3d 1249 (10th Cir. 1998)

   The Tenth Circuit held that Kansas's statutory subrogation right is not subject to a reduction for the recipient's contributory negligence when the recipient and the third-party reach a settlement. Here, a woman was injured in an automobile accident and sued the auto manufacturer. The state had paid plaintiff's medical treatment and the court ordered that almost all of the settlement proceeds were to be paid to the state as reimbursement for the money spent for Ms. Copeland's care. Ms. Copeland appealed, arguing that under K.S.A. § 39-719a, the state's portion of the settlement proceeds should be reduced by the percentage of Ms. Copeland's negligence. Ms. Copeland submitted evidence that, at the time of the accident, she had been drinking and was speeding.

   The Court found that any reduction of recovery under K.S.A. § 39-719a only occurs in conjunction with a recovery made pursuant to K.S.A. § 60-258a, Kansas's comparative negligence statute. Section 60-258a contemplates a full

trial on the merits. In cases where settlement is reached before trial, such as in *Copeland*, there is no reduction of recovery because 60-258a does not apply.

9. *Wishon v. Cossman*, 268 Kan. 99 (1999)

In *Wishon*, the court focused on the change in statutory language of Section 44-504(b) following the 1993 legislation session. The Kansas legislature removed the statutory language that was at issue in *McGranaham*, which stated that the employer "shall have a lien therefore against such recovery." In its place, the legislature essentially codified *McGranaham* stating that the employer:

> ...shall have a lien therefore against the entire amount of the recovery excluding any recovery, or portion thereof, determined by a court to be loss of consortium or loss of services to a spouse. The employer shall receive notice of the action, have a right to intervene and may participate in the action. The district court shall determine the extent of participation of the intervenor, including the apportionment of costs and fees.
>
> K.S.A. 44-504(b)

The subrogation lien is to be against the "entire amount" of the recovery attributable to the employee, excluding any recovery for loss of consortium or loss of services to a spouse. The carrier, however, is only subrogated to a third-party recovery which duplicates the actual workers' compensation benefits paid. At the time of *McGranaham*, the statute granted a lien "against such recovery." The current version of the statute grants a statutory lien "against the entire amount of such recovery." In *Wishon*, the court indicated that this was a distinction without a difference. It noted that Section 44-504(b) had a two-fold intent: (1) to preserve injured worker's claims against third party tortfeasors; and (2) to prevent double recoveries by the injured workers. *Lemery v. Buffalo Airways, Inc.*, 14 Kan. App. 2d 301 (1990).

Despite a workers' compensation lien in excess of $55,000, the court allowed recovery of only $16,890.98, which was the amount it paid in medical benefits. This was because the plaintiff did not offer any evidence or attempt to recover lost wages from the tortfeasor in the underlying third-party action. The court indicated that the legislature provides a means to prevent circumvention of the statutory lien by mandating notice, authorizing intervention, and providing for district court supervision. Therefore, if the carrier is apprehensive about the strength of its lien, the court in *Wishon* suggests that it intervenes to protect its lien. The Court of Appeals opined that if widow and the children did not release the tortfeasor and preserve their claims against him, then the rule in Kroeker applies.

10. *Smith v. Russel*, 274 Kan. 1076 (2002).

There is no requirement, under the Workers' Compensation Act, that a potential subrogation lienholder file a notice of lien to be subrogated to recovery from a third party, and such subrogation and creation of a lien occurs automatically. *Smith v. Russel*, 58 P.3d 698 (Kan. 2002). To protect and enforce its subrogation lien, the employer may intervene in the District Court proceeding that the employee initiates against the third party. The District Court shall determine the extent to which the intervenor may participate and apportion the costs and fees.

B. MISSOURI

1. *Ruediger v. Kallmeyer Bros. Service*, 501 S.W.2d 56 (Mo. 1973).

The Missouri Supreme Court interpreted the calculation requirements as set forth by § 287.150.3 as follows:

> "(1) the expenses of the third party litigation should be deducted from the third party recovery; (2) the balance should be apportioned in the same ratio that the amount paid by the employer at the time of the third party recovery bears to the total amount recovered from the third party; (3) the amounts due each should be paid forthwith; (4) the amount paid the employee should be treated as an advance payment on account of any future installments of compensation; and (5) in a case such as presented here, the employee should be entitled to future compensation benefits in the event the amount paid him as an advance is exhausted under the provisions of the statute."
>
> Calculation Example:
>
> $51,000.00 Total Workers Compensation Lien
>
> $75,000.00 Settlement
>
> -$35,000.00 Attorney fees and expenses
>
> $40,000.00 Net Recovery for lien and claimant From Third Party Settlement
>
> Reudiger Percentage
>
> $51,000.00 Workers' Comp Lien
>
> $75,000.00 Total Settlement
>
> = 68%
>
> Workers Comp Lien Recovery $40,000.00 * .68 = $27,200.00

2. *Kinney v. Schneider National Carriers, Inc.*, 200 S.W.3d 607 (Mo. App. W.D. 2006).

   In *Kinney*, the Court of Appeals found that employers are not entitled to an intervention of right in an action by the employee against a third party. In this case, the employee was involved in a motor vehicle accident and recovered workers' compensation from his employer's insurer. He then filed a petition against certain third parties to recover for personal injuries under a negligence theory. The employer sought to intervene to protect its subrogation rights pursuant to § 287.150.

   The Court of Appeals held that § 287.150 does not confer an unconditional right to intervene on the employer. The language of the statute merely gives the employer a "subrogation interest," but nowhere does it expressly state that the employer has a right to intervene. The Court further held that intervention is not necessary in order to protect the employer's interest in the outcome of the litigation. In theory, the employer's right to recover compensation paid is adequately represented by the employee who seeks to maximize total recovery and § 287.150 which causes a lien to attach to any amount to which the employer is entitled. Therefore, an employer or insurer's right to intervene in an action against a third party is purely at the court's discretion.

3. *Doss v. Howell-Oregon Electric Coop., Inc.*, 158 S.W.3d 778 (Mo. App. S.D. 2005).

   In *Doss*, the court in determining a jurisdictional issue, set forth all of the ways that an insurer has an opportunity to recover for workers' compensation paid to an employee.

   "The manner in which rights under § 287.150, RSMo 2000 may be invoked, which may lead to a workers' compensation insurance carrier who paid workers' compensation benefits to an employee recouping those payments from the third-party tortfeasor, need not take a singular form. The insurance carrier may intervene in the suit brought by the employee (or the employee's representatives) against the third-party tortfeasor. The insurance carrier may file a separate suit against the third-party tortfeasor after a cause of action between the employee and third person has been settled or arrived at a verdict.

   "Other options include the insurance carrier filing a declaratory judgment action against the employee after the employee's suit against the third-party tortfeasor has been resolved. Yet another method is for the employee to file a declaratory judgment action against the insurance carrier when the parties are unable to agree on the application of § 287.150.3, RSMo 2000. We also find cases in which an employee's attorney or an attorney for one of the employee's dependents files

an interpleader action to determine the appropriate distribution of settlement proceeds." (citations omitted).

4. *ATS, Inc. v. Listenberger*, 111 S.W.3d 495 (Mo. App. E.D. 2003).

   The employer does not have a subrogation interest in a legal malpractice case, when the malpractice claim is based on the attorney's failure to timely file a negligence action against a third party for personal injuries. In *ATS*, the injured employee hired an attorney to bring suit against a negligent third party. The attorney failed to timely file, and the suit was dismissed. The employee settled the ensuing legal malpractice case with his former attorney. The employer sought a declaratory judgment giving it a subrogation interest in the legal malpractice recovery.

   The Court ruled that the definition of "injury" as used in § 287.150 only applies to physical injuries and not to pure economic loss. The employer argued that denying a subrogation interest would result in double recovery by the employee who has already received workers' compensation money. The court pointed out that employers have a right to sue third party tortfeasors on their own accord, and therefore could get the same double recovery by suing their own attorney for malpractice and getting a subrogation interest in the employee's legal malpractice recovery. Any windfall that may exist should lie in favor of the injured employee, so employers are not entitled to a subrogation interest in legal malpractice claims arising out of a work injury.

5. *Sommers v. Hartford Accident and Indemnity Co.*, 277 S.W.2d 645 (Mo. App. 1955).

   In *Sommers*, a minor was injured when a driver negligently ran into her while she was at work. The employee's parents filed suit against the third party on her behalf, and in the claim, they only included damages that were not compensable under workers' compensation. The insurer asserted a subrogation interest in the third party recovery, but the employee opposed such entitlement. The employee argued that (1) her petition did not include damages that were compensable, and the subrogation lien cannot attach to recovery stemming from other damages, and (2) because she was a minor, the right to recovery vested in her parents, so she technically had no right to recovery.

   The Court dismissed the first argument reasoning that the employee, by initiating a third-party action, acts in trust for the employer who has already provided compensation. The employee must protect the subrogation rights of the insurer and cannot extinguish the subrogation interest merely by voluntarily excluding a prayer for the compensable damages. Furthermore, the court rejected the

argument that the employee herself never had any right to recovery. This situation is analogous to if the minor had actually paid for her damages out of pocket. In that situation, the parents would sue on her behalf, but she would still have the "right to recovery." The fact that an employer has a contractual obligation to pay for those damages, rather than the employee, does not change the fact that the parents are only suing on behalf of the minor. Even though the parents obtain the judgment, the employee still has the right to recovery for the purposes of the employer's subrogation interest.

6. *William H. Pickett, P.C. v. American States Family Insurance Company*, 857 S.W.2d 309 (Mo. App. W.D. 1993).

   In *Pickett*, the court upheld an award to the insurer of pro rata interest that accrued on the subrogation amount of a third-party settlement. The employee's attorney brought an interpleader action to determine the amount of the employer's subrogation interest. After the settlement between the employee and the third party, the employee's attorney placed the settlement amount in an interest bearing interplead fund pending the outcome of the interpleader action. Upon determining the amount of the employer's subrogation interest, the trial court awarded the employer a pro rata share of the interest that had accrued. The employee appealed the award of interest.

   The Court of Appeals upheld the award of a pro rata share of interest to the respective parties. Interpleader is an equitable remedy, and therefore "allowance of prejudgment interest is a matter of discretion." The employer is entitled to its share of any third-party recovery as soon as it is awarded. While the interpleader action was underway, the employer lost the ability to use the money to which it was entitled. The pro rata share of interest was compensation for the employer's loss of the use of that money, and therefore was properly awarded by the trial court.

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SOCIAL SECURITY & RETIREMENT

I. Social Security

A. Social Security is a government program implemented in the United States designed to provide income and support to eligible individuals and families during retirement, disability, and after the death of a worker. The program will typically be funded through payroll taxes paid by both employees and employers.

B. Social Security Key Features:

i. Retirement Benefits

1. Social Security offers a retirement benefit known as the Old-Age, Survivors, and Disability Insurance (OASDI) program. Eligible individuals receive a monthly payment based on their earnings history and the age at which they choose to begin receiving benefits.

ii. Disability Benefits

1. Social Security provides financial assistance to individuals who are unable to work due to a disability, helping them meet their basic needs and medical expenses.

iii. Survivor Benefits

1. Social Security supports the surviving dependents of deceased workers, including spouses, children, and sometimes parents, by providing monthly benefits to help with living expenses.

iv. Medicare

1. Social security administers Medicare, a healthcare program that provides medical coverage to those aged 65 or older, or those with certain disabilities.

C. Certain programs have been designed to provide assistance to individuals who meet government requirements for disability.

i. Social Security Disability Insurance (SSDI)

1. SSDI Program pays benefits to the disabled individual and certain family members if the disabled individual is “insured.”
2. Individual must work long enough, and recently enough, and paid Social Security taxes on his/her earnings.

ii. Supplemental Security Income (SSI)

1. SSI Program pays benefits to adults and children who meet disability qualifications and have limited income and resources.

D. Social Security benefits are not the same disability benefits.

E. Workers Compensation benefits typically will be easier for an individual to get over SS disability because WC covers partial disabilities.

F. Workers Compensation and other public disability benefits may reduce any Social Security benefits being received.

II. Retirement

A. Retirement Planning

i. Process of setting aside funds and making decisions to ensure a comfortable and financially secure retirement. It often involves multiple cannels of funding, whether it be through personal savings, investments, and/or employer-sponsored retirement plans, such as a 401(k) or pension plan(s).

B. Full retirement age

i. Born 1955 or later = 67 years old

ii. Born 1943-1954 = 66 years old

C. Benefits

i. $$ for $$ credit for all payments made

1. Employer pays toward it, so every dollar paid receives credit.
2. Considered income.

ii. Self-funded pension is paid by employer.

iii. Employer must prove that they paid for it.

1. Example: KPERS must get an affidavit.

iv. Employer may choose in what capacity they pay beneficiary.

1. Example: Goodyear might pay by lump-sum, monthly, bi-weekly, or weekly.

III. Social Security Can Work Together

A. Income Source

i. Social Security can and does serve as a vital income source for many retirees. It provides a baseline of income that individuals can rely on during their retirement years. However, social security benefits alone may not be sufficient to meet all of one's expenses, which is where proper retirement planning can help to bridge the gap (with accumulated funds).

B. Retirement Age

i. Social Security benefits are influenced by the age that individuals choose to begin receiving them. Retirement planning must include considering the optimal age to claim Social Security benefits, so as to maximize their value.

C. Supplementing Retirement Savings

i. Social Security benefits provide individuals with additional income at the point they begin receiving them. This additional income source helps individuals achieve a more comfortable and financially secure retirement.

D. Healthcare Coverage

i. Social Security's Medicare program provides health insurance to retirees, helping them manage medical expenses during retirement. However, retirees may still need to plan for additional healthcare costs not covered by Medicare, such as long-term care, supplemental insurance, or prescription medications.

Ⅳ. Social Security Retirement Offset - K.S.A. 44-501(f)[1] (KS Rule)

A. Allows the employer to offset workers compensation benefits against social security retirement benefits. This dollar-for-dollar offset gives the employer's insurance carrier a credit against both temporary and permanent weekly disability payments.

B. "If you receive workers compensation or other public disability benefits, and SSDI benefits, the total amount of these benefits cannot exceed 80% of your average current earnings before you became disabled." (SSA)

i. Each of us have payroll taxes deducted from our paychecks. These contributions to FICA fund-in part- social security retirement. The employer also pays payroll taxes. Both employee and employer fund social security retirement. Despite this, the employer is allowed under the Kansas Workers Compensation Act a credit for the payments the employee contributes to social security.

[1] If the employee receives, whether periodically or by lump sum, retirement benefits under the federal social security act or retirement benefits from any other retirement system, program, policy or plan which is provided by the employer against which the claim is being made, any compensation benefit payments which the employee is eligible to receive under the workers compensation act for such claim shall be reduced by the weekly equivalent amount of the total amount of all such retirement benefits, less any portion of any such retirement benefit, other than retirement benefits under the federal social security act, that is attributable to payments or contributions made by the employee, but in no event shall the workers compensation benefit be less than the workers compensation benefit payable for the employee's percentage of functional impairment. Where the employee elects to take retirement benefits in a lump sum, the lump sum payment shall be amortized at the rate of 4% per year over the employee's life expectancy to determine the weekly equivalent value of the benefits.

C. How the Offset is Calculated by the SSA

i. The SSA bases its calculation of the offset for a dual SSDI/workers compensation recipient on what it calls the “applicable limit.” Once this limit is determined, you cannot receive more in benefit payments than the limit allows, and your SSDI will be adjusted downward to bring things into alignment.

ii. The applicable limit is based on the higher of these two figures:

1. 80% of the worker’s pre-injury income, known as “average current earnings,” or
2. The total of SSDI received by all family members of the recipient’s family in the first month of payment by workers compensation, known as “total family benefit”.

iii. Generally, the average current earnings will be higher, and the SSA will use that figure.

D. How Average Current Earnings is Calculated

i. The SSA bases its calculation of the offset for a dual SSDI/workers compensation recipient on what it calls the “applicable limit.” Once this limit is determined, you cannot receive more in benefit payments than the limit allows, and your SSDI will be adjusted downward to bring things into alignment.

1. The applicable limit is based on the higher of these two figures:
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3. The total of SSDI received by all family members of the recipient’s family in the first month of payment by workers compensation, known as “total family benefit”.

ii. Generally, the average current earnings will be higher, and the SSA will use that figure.

E. How the Offset Works

i. Assume your average current earnings are calculated to be $4,000 a month. That would make you and your family eligible for $2,200 a month in SSDI benefits, but you also receive $2,000 a month in workers compensation benefits. This brings your total of benefits to $4,200, which is more than 80% of $4,000 (your average earnings), which computes to $3,200 a month. In this case, your SSDI will be reduced by $1,000 a month to bring your total benefits in line with the 80% ceiling of $3,200.

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TOXIC EXPOSURE CLAIMS IN MISSOURI

I. TOXIC EXPOSURE 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.

VII. 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.

VIII. § 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.

IX. WHO CAN COLLECT ENHANCED REMEDY BENEFITS?

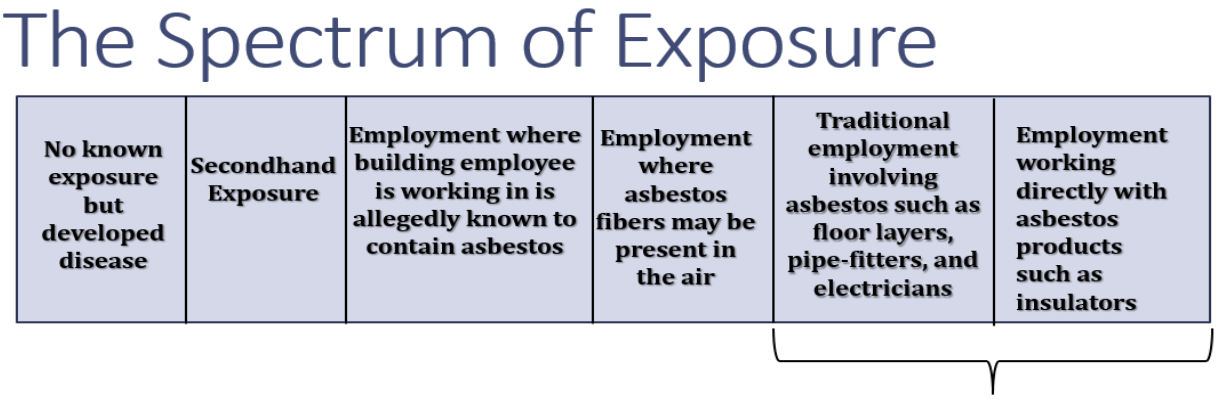
A. Enhanced Remedy benefits payable to:
   i. Employee's spouse.
   ii. Children (natural, adopted, legitimate, or illegitimate).
   iii. Estate of employee.
B. Traditional Benefits, on the other hand, are only payable to dependents:
   i. Employee's spouse or children under the age of 18 or 22, depending on the situation
   ii. If no dependents, only pay medical and/or burial expense on death case.

X. 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.



XI. 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.

XII. 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.

XIII. RECENT DECISIONS

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 and the Court affirmed the decision of the Commission.

XIV. 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?
xi. What is the result when the insurer at the time of exposure is indeterminable?
xii. Whether the safety penalty contained within § 287.120.4 is applicable.

XV. 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 thecourse 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 withthe employment and to have flowed from that source as a rational consequence.
   iii. Occupational diseases do not include ordinary disease of life to which thegeneral public is exposed outside of the employment (287.067.1).
   iv. If the disease follows as an incident of employment than it can beconsidered 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 becompensable. (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. The date of loss listed will state “up until” a certain date or list ageneralized time period such as “September 2020.”

D. Red Flags for Occupational Disease/Repetitive Trauma Claims
   i. The employer denies ever 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 diseaseclaim when they have filed a claim for an acute injury.
   vi. If opposing counsel will not provide relevant information about the natureof the claim, options include requesting a pre-hearing or scheduling the claimant's deposition.

XVI. 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 throughdeposition
   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 informationabout the claimant's condition

C. Defense Strategy:
   i. Identify the appropriate date of occupational disease
      - The date of injury listed on the Claim for Compensation is usually completely arbitrary
      - The appropriate date provides guidance for the entire defense process

D. Determine the strength of a potential medical causation defense
   i. Job duties
      a. What does the claimant report about his/her job duties?
      b. What does the employer report about the claimant's job duties?
      c. Ergonomic analysis

E. Non-occupational risk factors
   i. Diabetes
   ii. Rheumatoid arthritis
   iii. Obesity
   iv. Sex
   v. Age

XVII. 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'sability 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 **harmedthe 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 manufactureas 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.

XVIII. 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 hazardof the occupational disease *prior to evidence of disability*,** regardless of thelength 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, EmployerB 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 theinjury, the prior employer shall be liable for such occupational disease.287.067.8

ii. The exception is a two-part test:

a. The exposure to the repetitive motion which is found to be the cause ofthe injury is for a period of less than three months; AND

b. The evidence demonstrates that the exposure to the repetitive motionwith the immediate prior employer was the prevailing factor in causingthe injury.

iii. Exception Example:

a. The claimant worked for Employer A from 1/1/1995 to 12/31/2015 (20years). The job duties for Employer A were very hand intensive.

b. On 1/1/2016, the claimant began working for Employer B. The jobduties for Employer B were identical and hand intensive.

c. The claimant begins noticing numbness and tingling in his hands andwrists 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).

d. The claimant was employed for less than 90 days with Employer BAND the repetitive motion with the immediate prior employer (Employer A) was the prevailing factor in causing the injury.

e. Employer A is most likely to be liable.

XIX. 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 applicablewhen 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 discoverableand 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).

XX. INVESTIGATIONS AND DENIALS

A. Non-litigated cases – employee reports the occupational disease
   i. File the report of injury
   ii. Take a recorded statement
   iii. Determine the date of hire
   iv. Job duties
   v. Job history
   vi. Medical treatment
   vii. Primary care physician
   viii. Onset of symptoms
   ix. 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 liableemployers and insurance carriers
   vi. Take the claimant's deposition
   vii. Schedule an IME

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HOW TO HANDLE MEDICAL FEE DISPUTES

I. MEDICAL FEE DISPUTES ("MFD")

A. A type of proceeding filed by a healthcare provider to dispute payment of medical treatment.

II. TWO TYPES OF MFDS

A. Reasonableness Disputes
   i. The medical bill has been authorized and partially paid by the employer or insurer.

B. Direct Payment Disputes
   i. Treatment is authorized yet no payment has been made.

III. 8 MO. CODE OF STATE REGULATIONS 50-2.030

A. Sets forth the Division of Workers' Compensation administrative procedures available to employers, insurance carriers and health care providers to resolve disputes concerning charges for health care services.

IV. PROCEDURE FOR APPLICATION OF REASONABLENESS DISPUTES

A. Dispute is in excess of $1,000.
   i. $1,000 or less – no discovery
   ii. $1,000 or more, parties may engage in discovery.

B. Issue involves reasonableness and fairness of medical bills.

C. The MFD is filed separately from the case.

D. Statute of Limitations
   i. Two years from the date of first notice of dispute of medical charges by health care provider if services were provided before July 1, 2013.
   ii. If services were provided after July 1, 2013, one year from the date of notice of medical charge received by the healthcare provider.

E. Process
   i. Health care provider files an Application for Payment of Additional Reimbursements of Medical Feeds with the Division.
   ii. The health care provider serves a copy on the employer of insurer by personal service or certified mail.
   iii. An MFD number is assigned to the dispute.
   iv. All parties are notified if an optional evidentiary hearing takes place. This occurs if parties cannot resolve the dispute.

v. Within 30 days of the application, the employer or insurer is required to file an Answer to Application for Payment of Additional Reimbursement of Medical Fees.
vi. The hearing is conducted by an administrative law judge and an award is issued.
vii. Most cases, however, settle.

F. If the amount in dispute is less than $1,000, either party may file a written request for an administrative ruling procedure.
   i. The administrative law judge issues an award within 30 days of the hearing.
   ii. Parties may file an application for review with the Labor and Industrial Commission within 20 days of the administrative law judge's decision.

V. TIMBERLAKE LIRC DECISION

A. This decision states that evidence relevant to the amount paid by a private health insurer, Medicaid, Medicare, or patient does not matter.

B. All parties are charged the same amount, so the dispute must show the billed amount is not "fair and reasonable".

VI. PROCEDURE FOR DIRECT PAY DISPUTES

A. The employer or insurer refuses to pay for medical treatment that the health care provider contends were authorized under Missouri Workers' Compensation Law.

B. Process
   i. There must be a report of injury or claim for compensation on file.
   ii. Health care provider files a Notice of Services Provided and Request for Direct Payment with the Division
   iii. The health care provider serves a copy on the employee and employer/insurer by means of personal service or through certified mail.
   iv. The Division assigns a Medical Fee Dispute Number
   v. In a direct payment dispute, the health care provider is made a party to the workers' compensation case
   vi. The health care provider may present evidence at any evidentiary hearing.

VII. DEFENSES

A. Services did not pertain to a compensable injury.

B. Services were not authorized.

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BACK(PAIN) TO THE FUTURE

I. FUTURE MEDICAL TREATMENT - Overview

A. The need or lack thereof for future medical care must be considered in every case.

B. Federal regulations require Medicare's interest with respect to future medical treatment to be considered in every case.

C. If future medical treatment is necessary after MMI, there are multiple options for addressing future medical treatment needs of the injured worker. These include resolving with open medical benefits, funding a future medical allocation, funding a Medicare Set-Aside, and leaving open future medical benefits for a specific purpose.

D. It is important to have treating physicians and IME physicians address the likelihood of future medical treatment for the work injury.

II. OPTIONS TO ADDRESS AN INJURED WORKERS' FUTURE MEDICAL TREATMENT NEEDS IN A WORKERS' COMPENSATION SETTLEMENT

A. Following a workers' compensation hearing, the judge or arbitrator may, depending on the jurisdiction, determine there is no need for future medical treatment and thereby "close" medical benefits. In other jurisdictions, future medical treatment benefits are automatically left "open" following a hearing.

B. When addressing future medical treatment as part of a settlement, there are several options:

   i. Leave medical benefits open as part of the settlement agreement.

   ii. Fund a Medicare Set-Aside

   iii. Fund a Future Medical Allocation

   iv. Leave medical benefits open only for a specific purpose (such as hardware removal)

   v. Lump sum payment as part of the settlement to address any disputed need for future medical treatment.

III. OPEN MEDICAL BENEFITS

A. In the terms of a workers' compensation settlement agreement, the parties can agree that the Employer/Insurer remains liable for any future medical treatment. The benefits of this approach include:

   i. In jurisdictions where the Employer/Insurer directs medical treatment, the Employer/Insurer can maintain this right for future medical treatment.

   ii. Leaving medical benefits open can reduce subsequent claims to the same body part in the future.

   iii. Leaving medical benefits open can be more cost effective than other options depending on the facts of a particular case.

iv. At a later date, if the parties agree, the parties can present a motion to close future medical benefits for a sum of money or a future medical allocation, MSA, etc.

IV. FUNDING A MEDICARE SET-ASIDE

A. In every workers' compensation settlement, the parties must consider Medicare's interests. One way to show the parties adequately considered Medicare's interests is through the funding of a Medicare Set-Aside that is approved by The Centers for Medicare and Medicaid Services (CMS). CMS will review a Medicare Set-Aside for approval when the following apply:

   i. The claimant is currently a Medicare beneficiary and the total settlement amount is greater than $25,000.00; OR

   ii. The claimant has a "reasonable expectation of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.00.

B. How does one become a Medicare Beneficiary:

   i. 65 years of age or older.

   ii. Has been "entitled" to Social Security Disability (SSDI) benefits for greater than 24 months.

      1. Entitlement date comes after 5 full calendar months have passed from the "disability" date.

      2. "Disability date" is often the date of accident or the date the claimant stopped working.

      3. Therefore, Medicare eligibility arises on the first day of the calendar month 29 months after the date of "disability" in the Social Security Disability Award.

   iii. End stage kidney failure

C. Options for funding a Medicare Set-Aside

   i. Lump sum

   ii. Annuity

   iii. With professional administration (preferred by CMS)

   iv. Self Administration

D. Considerations for Non-Medicare Covered Future Medical Treatment

V. FUNDING A FUTURE MEDICAL ALLOCATION

A. The terms “Future Medical Allocations” and “Medicare Set-Asides” are often used interchangeably. For purposes of this presentation, “Future Medical Allocations” refer to a professionally determined future medical cost projection that is funded similar to a Medicare Set-Aside, but is not submitted to CMS for approval.

B. Similar options for funding as a Medicare Set-Aside

VI. OPEN MEDICAL BENEFITS FOR A SPECIFIC PURPOSE

A. As part of the settlement agreement, in some jurisdictions the parties can agree that future medical benefits for a specific treatment only remains open.

B. In Missouri Section 287.140.8 of the Missouri Workers’ Compensation Act provides, in relevant part: *The employer may be required by the division or the commission to furnish an injured employee with artificial legs, arms, hands, surgical orthopedic joints, or eyes, or braces, as needed, for life whenever the division or the commission shall find that the injured employee may be partially or wholly relieved of the effects of a permanent injury by the use thereof…a claim for compensation may be reactivated after settlement of such claim is completed. The claim shall be reactivated…and the claim shall be made only for the payment of medical procedures involving…the use of a new, or the modification, alteration or exchange of an existing prosthetic device.”* The Commission has interpreted this section to essentially include any hardware. (See *Gamble v. Chester Bross Construction Company*, 2015).

VII. LUMP SUM PAYMENT FOR DISPUTED FUTURE MEDICAL TREATMENT

A. As part of the settlement, the parties can include a lump sum payment to the injured worker, in addition to permanent partial disability, for any disputed future medical treatment needs the injured worker may have.

VIII. OTHER CONSIDERATIONS

A. The role of the treating physician in addressing future medical treatment considerations or the absence of any need for future medical treatment is vital.

B. Settling a case before claimant’s counsel obtains an independent medical examination can be beneficial, depending on the case, as experts used by claimants’ attorneys often suggest medical treatment will be needed in the future as a result of the work injury.

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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. 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.

D. Iowa – Medical Marijuana for Epilepsy – HB 524 passed May 12, 2017

i. Does not address employer's responsibilities

ii. Does not address discrimination

E. Kansas – Illegal

i. According to a 2021 Statute 44-501(b)(1)(A), the employer shall not be liable under the workers compensation act where the injury, disability or death was contributed to by the employee's use or consumption of alcohol or any drugs, chemicals or any other compounds or substances, including, but not limited to, any drugs or medications which are available to the public without a prescription from a health care provider, prescription drugs or medication, any form or type of narcotic drugs, marijuana stimulants, depressants or hallucinogens.

ii. This new bill also includes protections for registered medical marijuana patients who are injured in the workplace.

iii. This bill was not taken up by the Kansas Senate in 2021

F. Missouri –

i. Medical Marijuana legalized in 2018

1. Qualifying Medical Conditions listed in Article XIV of the Missouri Constitution
    - Cancer
    - Epilepsy
    - Glaucoma
    - Intractable migraines unresponsive to other treatment
    - A chronic medical condition that causes severe, persistent pain or persistent muscle spasms, including but not limited to:
        - Multiple Sclerosis
        - Seizures
        - Parkinson's disease
        - Tourette's syndrome
    - HIV or AIDS
    - Debilitating psychiatric disorders, ex. PTSD
    - A terminal illness
    - A chronic medical condition that is normally treated with a prescription medication that could lead to physical or psychological dependence.
    - In the professional judgement of a physician, any other chronic, debilitating, or other medical condition including:
        - Hepatitis C, amyotrophic lateral sclerosis, inflammatory bowel disease, Crohn's disease, Huntington's disease, autism, neuropathies, sickle cell anemia, Alzheimer's, cachexia, and wasting syndrome

ii. Recreational use passed in 2022 as a Constitutional Amendment

1. Section 2 of Article XIV of the Missouri Constitution
2. Legalized recreational marijuana for adults 21 and older and expunged records of past arrests and convictions for nonviolent marijuana offenses.
3. Sales began in February 2023

G. Nebraska – Illegal

H. Oklahoma – Medical Marijuana for chronic conditions only passed 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

iii. Suspension of payments

iv. Termination or suspension of the contract

v. Prohibition from future federal contracts up to five years

vi. 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 Americans 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

iv. ADA defines illegal use of drugs as use of drugs that are unlawful to distribute or possess under the CSA, which includes marijuana.

v. 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).

vi. 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)

vii. 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.

viii. 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.

1. 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).

ix. 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

1. 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)

x. Protects all employees from the employer uncovering the employee's health defects at its own direction.

xi. 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
        a. 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)
        b. Able to ask about non-disability impairment and illegal-drug abuse.

xii. 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)
        b. An employee's ability to perform essential job functions will be impaired by a medical condition; or
        c. An employee will pose a direct threat due to a medical condition
        d. Significant risk to health or safety of others that cannot be eliminated by reasonable accommodation
        e. 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. Respondent 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.

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