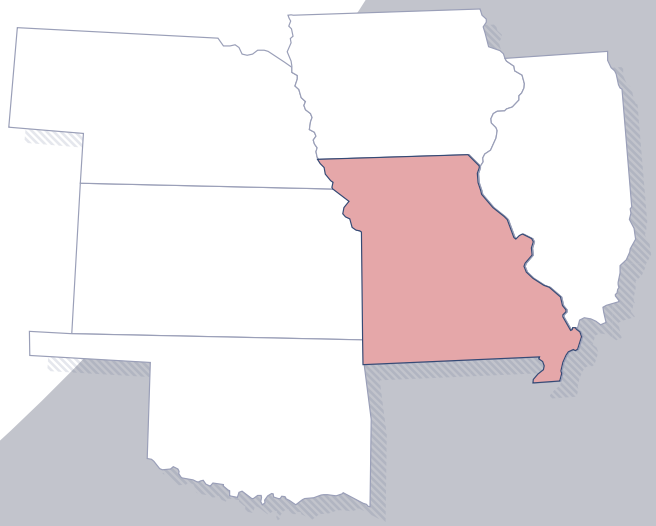
Workers' Compensation Reference Guide

Missouri



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. <u>Vocational Rehabilitation</u>

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 is 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 employee’s 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 $621.51.
    c. Value of rating would be $24,860. (400 weeks X 10% X $621.51)

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 include 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 needs 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 amount the employee receives.
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.

RECENTLY ASKED QUESTIONS IN MISSOURI

FROM ISSUES ADDRESSED IN RECENT MISSOURI CASES

Q: Must outward signs of an injury be immediately noticeable in order to meet the "objective symptoms of an injury" requirement of the "accident" statute?

A: Not necessarily. Harper, a nurse, left the workforce because of a neck surgery that made her unable to walk. Fortunately, Harper recovered the strength to walk independently and returned to work as a nurse but made some small changes. Her job duties consisted of calling doctors, talking to hospitals, walking hallways to check on patients, and distributing medications. The medications were distributed from a wheeled cart that nurses would push themselves.

On June 22, 2018, Harper was leaving a patient's room and encountered one of the larger medical carts in the hallway. To move this, she forcefully pushed the cart against the wall using her hips and back. This caused her to feel a pull in her back. Although she continued to work, by the end of the shift she was having difficulty walking. She struggled to work the next day and she visited a doctor. She was diagnosed with a low back injury, placed on work restrictions, and prescribed medications.

After the injury, Harper called into work multiple times claiming a difficulty physically getting out of bed. She was eventually terminated. In turn, Harper filed a Claim for Compensation. To support her claim, Dr. Koprivica testified that Harper experienced an injury from the cart incident and concluded she has 25% PPD of the body as a whole. Her employer argued she did not suffer an "accident" pursuant to § 287.020.2 because the alleged injury did not result in objective symptoms at the time.

The Supreme Court of Missouri disagreed with the employer and found Dr. Koprivica's testimony credible related to the imaging of Harper's injury arising out of pushing the cart. Harper's testimony, combined with Dr. Koprivica's interpretation of the imaging studies, was sufficient to meet her burden of proving she suffered an accident pursuant to § 287.020.2.

Harper v. Springfield Rehab & Health Care Ctr./NHC Health, 687 S.W.3d 613 (Mo. 2023), reh'g denied (Jan. 30, 2024)

Q: Did the Commission err in admitting evidence that the employer paid claimant's medical bills and failed to award attorney fees based on the total amount of the medical bills?

A: No. Roe, an employee, cut her finger at work. She immediately notified her manager of the injury. Over the following days, the cut became infected and resulted in emergency hospitalization. Her employer sent her to Corporate Care after hospitalization. In total, Roe incurred medical expenses of $30,879.21. Due to these bills, Roe hired a lawyer to file a claim for compensation. Therefore, she signed a fee agreement in which the attorney

would receive 25% of all benefits paid, and the agreement included 25% of Roe's incurred medical bills resulting from her injury.

In filing the claim for compensation, Roe's attorney filed the claim, sent letters and emails, and sent Roe for an independent medical exam. The attorney sent a letter in May 2019 to the employer's attorney acknowledging that he had placed a 25% lien on the gross proceeds of the case, including the medical bills, and asked that the employer send payment of the medical bills to their office. In January 2020, following a discussion with the Administrative Law Judge, the employer paid Roe's medical bills. Nevertheless, Roe was unaware that the medical bills were paid despite the employer informing her attorney and providing proof of payment. Roe's attorney also continued to pursue payment of her medical bills despite being sent the letters.

At Trial, one of the disputed issues was whether Darden Restaurants needed to reimburse Ms. Roe for medical expenses totaling $30,879.21, despite the employer negotiating the price down. To show proof of payment, Darden Restaurants (her employer) introduced into evidence nine separate checks written from the insurance company to Roe's medical providers with accompanying explanations of benefits itemizing all expenses paid. Roe objected to this evidence at trial, but it was overruled.

After the hearing, the ALJ awarded PPD and disfigurement, but not the bills. The Missouri Court of Appeals affirmed the Commission's denial of medical benefits. The court noted that "If [Roe]'s attorney did not believe employer's counsel, a fellow member of the bar, a more direct and easier way to determine that said bills had been paid would have simply been to contact the medical providers to confirm such information. Further it is concerning to this [c]ourt that based on the evidence, [Roe]'s attorney made no effort to advise his client that the employer had informed him that the bills would be paid or that reported proof of payment of the bills had been received by him or that the bills had been paid on her behalf."

The Commission therefore acted within its authority under § 287.260 in determining the fair and reasonable amount of Roe's attorney fees to compensate for services rendered in "obtaining payment of her medical bills as well as permanent partial disability benefits."

Roe v. Darden Restaurants, Inc., 677 S.W.3d 568 (Mo. Ct. App. 2023), reh'g and/or transfer denied (Oct. 3, 2023), transfer denied (Nov. 21, 2023)

Q: Does an employer's untimely Answer preclude it from disputing the issue of whether the claimant sustained compensable occupational disease arising out of and in the course of employment?

A: No. Collins worked as a concrete driver, where he would spend substantial portions of time sitting in the same truck. The seats in employer's concrete trucks were made from metal with a cushion that was worn out. The truck also had vibrations coming from the

diesel engine, which caused him to experience jarring. Collins had prior back pain, but it eventually reached a constant pain level of six out of ten. This injury impacted many portions of his life beyond work, eventually requiring steroid injections and back surgery. Because of this, Collins informed his employer that it could be work related. He eventually filed a claim for compensation which the employer answered 45 days later.

The claim for compensation alleged: On or about 4/02/18 in Lee's Summit, MO during the ordinary course and scope of his employment with Century Ready-Mix, Inc. and/or Century Concrete, Inc. as a truck driver/laborer, Jason Collins was exposed to occupational disease/cumulative trauma in a degree greater than or different from that which affects the public generally and some distinctive features of his job which was common to all jobs of that sort. As a direct, proximate, and prevailing factor of his occupational positioning and duties, he suffered back, right lower extremity, and body as a whole cumulative trauma or disease thereby directly causing permanent partial disability, temporary total disability, permanent total disability, past and future medical bills, and whole cost of the proceedings including attorney fees pursuant to R.S.Mo. § 287.560.

The Commission agreed with the ALJ that the employer's answer to Collins' claim for compensation was untimely, but concluded that the employer's untimely answer did not preclude it from disputing the issue of whether Collins sustained a compensable occupational disease arising out of his employment.

Unless the Answer to Claim for Compensation is filed within thirty (30) days from the date the division acknowledges receipt of the claim or any extension previously granted, the statements of fact in the Claim for Compensation shall be deemed admitted for any further proceedings. *8 CSR 50-2.010(8)(B)*

An untimely Answer results in the admission of how the injury occurred, medical causation, average weekly wage, and the date of the accident. However, legal conclusions are not admitted by an untimely Answer. This includes whether an injury arose out of and in the course of employment and the nature and extent of disability.

In sum, the Court of Appeals concluded the Commission is not bound to deem admitted all of the employee's allegations when the employer fails to timely answer the Claim. Therefore, claimant's assertion that he "was exposed to occupational disease/cumulative trauma in a degree greater than or different from that which affects the public generally and some distinctive features of his job which was common to all jobs of that sort," and that he suffered injury "[a]s a direct, proximate, and prevailing factor of his occupational positioning and duties" are legal conclusions and not factual statements that (1) the injury occurred, and (2) it occurred at work.

Collins v. Century Ready Mix, Inc., 678 S.W.3d 178 (Mo. Ct. App. 2023)

Q: Did the Commission err in finding that an expert witness was not credible and that claimant did not have preexisting disability resulting in a denial of benefits to the Second Injury Fund?

A: No. McCoy worked at Meridian Medical Technology, assembling autoinjectors used to treat allergic reactions. Prior to her injury, McCoy suffered from multiple health conditions, including morbid obesity, low back pain, asthma, ventral hernias, and pulmonary disease. In 2006, an ALJ even awarded McCoy workers' compensation benefits for an occupational disease arising out of the course of her employment. The ALJ determined McCoy sustained 17.5% PPD in each of her wrists. Her employer was found liable.

After that injury, McCoy continued working as an inspector. The primary injury occurred in 2017 after she was diagnosed with lateral epicondylitis of the right elbow arising out of the course of her employment. She filed a claim for benefits, alleging that her preexisting disabilities combined with her primary injury rendered her permanently and totally disabled. An ALJ held employer liable for 10% PPD of her right elbow. The ALJ also found the "preexisting disabilities and her body as a whole condition satisfied" and she was able to receive PTD benefits. On appeal. The Commission adopted the finding that the employer was liable for 10% PPD for the right elbow injury but found "the determination that McCoy was rendered permanently and totally disabled to be incorrect". The Commission argued that McCoy's expert witnesses were not credible.

McCoy argued that her preexisting bilateral carpel tunnel injury qualified as a compensable disability because it was a single work injury and resulted in 68.91 weeks of disability.

Court of Appeals stated: "when there are multiple disabilities in a compensation award, each preexisting disability must be evaluated individually to determine whether it satisfies the first condition of § 287.220.3(2)(a) to be considered a qualifying preexisting disability." Though, in her 2002 occupational disease claim, McCoy had a single claim, she suffered from two distinct disabilities. She therefore does not have a qualified preexisting disability.

On the matter of witness credibility, the Court of Appeals added that the Commission "is free to believe some, all or none of any witness's testimony."

McCoy then argued that the Commission erred in determining her body as a whole disability was a non-qualifying preexisting disability, and that the Fund did not introduce any expert testimony to contradict Dr. Volarich's conclusions. Yet the Court of Appeals noted the Commission did not find Dr. Volarich to be credible or persuasive, so there was no credible expert testimony to support Ms. McCoy's claims regarding her body as a whole disability. Therefore, the Commission's decision to deny benefits from the Second Injury Fund was sustained.

McCoy v. Meridian Med. Tech., 675 S.W.3d 740 (Mo. Ct. App. 2023), transfer denied (Sept. 26, 2023)

Q: Does a subsequent work-related injury prevent an Employee from being found permanently and totally disabled as a result of a prior work-related injury?

A: No. Watson injured his lower back in April 2015 when he caught a falling motor at work. In August 2015, he underwent a lumbar fusion, but it did not resolve his symptoms. Watson returned to work in January 2016 performing basically the same tasks as he was prior to the April 2015 injury. By February 2016, Watson twisted his neck and heard a pop while using a pneumatic tool at work. He treated the injury with heat and traction. By April 2016, he had decided to retire because he could no longer do the job and did not want to be terminated. Watson did not reach maximum medical improvement for the back injury until July 2016.

Watson filed a claim for compensation for both injuries separately. Dr. Koprivica, Watson's medical expert witness, argued that the work accident was the "direct, proximate, and prevailing factor causing the back injury which in isolation, rendered Claimant permanently and totally disabled." Dr. Belz, the medical expert for Employer, found neither the back injury nor neck injury "in isolation, met the requirements for [PTD], but when considered together with all prior injuries and a non-work-related degenerative condition, Claimant was permanently and totally disabled."

The Administrative Law Judge concluded that the April 2015 work injury was the prevailing factor in causing the resulting medical condition and disability in Watson's back. Then, the February 2016 work injury was the prevailing factor in causing the resulting medical condition and disability in Watson's neck. The ALJ added that Watson is permanently and totally disabled because of the April 2015 back injury, considered in isolation. Therefore, the Second Injury Fund is not liable because the "last injury" was the back injury, not the neck injury. The Commission affirmed the ALJ decision.

"If a claimant's last injury in and of itself rendered the claimant permanently and totally disabled, then the Second Injury Fund has no liability and employer is responsible for the entire amount." *Lewis v. Treasurer of State*, 435 S.W.3d 144, 157 (Mo. App. 2014).

The Employer argued against this ruling. Yet, the Court of Appeals found substantial evidence supported the ALJ's finding that the back injury alone rendered Mr. Watson permanently and totally disabled. Additionally, the occurrence of a subsequent work-related injury does not change the fact that Watson was already PTD at the time of the neck injury. In fact, the subsequent injury may have added to Watson's misery but did not make him more PTD.

One important note that the court highlights is that an employee can be permanently totally disabled without becoming completely inactive. Just because Watson has good fortune and could return to an accommodated employment does not preclude PTD. This is because the "test is whether the claimant could compete in the open labor market."

Watson v. Tuthill Corp., 672 S.W.3d 260 (Mo. Ct. App. 2023)

Q: If an employer is found to be liable for past medical expenses after denying a demand for medical treatment, does the employer automatically lose its right to direct future medical treatment?

A: No. Helmig worked for Employer as a counselor at an elementary school. During October 2010, she was injured on two occasions arising out of and in the scope of employment.

In the first incident, a student jumped from a chair onto the Claimant's shoulders and neck. In the second incident, Claimant stubbed her foot in a dip in a parking lot while chasing a runaway student and tripped. After these incidents, Helmig completed an incident report and requested medical treatment. Her employer authorized medical treatment. After she was discharged from her treatment, she was still experiencing continued pain and contacted the doctor again. That office informed her to contact her employer and request additional treatment. Further treatment was denied by the employer.

Using her own medical insurance, Helmig sought her own treatment from Dr. Thompson. He diagnosed Helmig with thoracic outlet syndrome; she has received surgery for the condition and had continuing therapy for pain management. Helmig incurred $184,957.24 in medical bills with unauthorized treatment.

The Administrative Law Judge handled this claim, and concluded Helmig's unauthorized treatment was reasonably required to cure and relieve from the effects of the work injuries. Therefore, the ALJ awarded her $152,935.67 in past medical expenses. The ALJ also awarded future medical but ordered the Employer to essentially authorize ongoing treatment with the health care providers selected by Helmig. On top of that, the ALJ also awarded a 25% fee to Helmig's attorney, which included the fee on the past medical awarded.

On appeal, the Commission modified the award. The Commission agreed that Helmig incurred fair, reasonable, and customary charges in the amount of $152,935.67 for medical treatment she sought on her own after the Employer stopped authorizing treatment for the work injuries. Moreover, instead of awarding the amount of the bills directly to Helmig, the Commission ordered the Employer to resolve the bills directly with the providers or issue payment for the expenses to Helmig. Finally, the Commission also required Employer to hold Helmig harmless for the past medical expenses associated with her treatment.

The modification stems from the ALJ award of future medical. The Commission disagreed with the ALJ's implicit finding that the Employers refusal to authorize medical treatment in the past justifies mandating that future treatment may only be provided by or at the direction of physicians Helmig has previously self-selected. Moreover, pursuant to § 287.140.1 RSMo, the Employer has the right to select the licensed treating physician, surgeon, chiropractic physician, or other health care provider; provided, however, that

such physicians, surgeons or other health care providers shall offer only those services authorized within the scope of their licenses.

In her appeal, Helmig argued that the Commission erred in ruling the Employer had the right to select Helmig's future medical providers. She also argued that the Employer waived its right to direct medical care by refusing to provide her medical treatment for 12 years. The Court of Appeals disagreed with Helmig, arguing that "the law is clear that when an employer fails to provide medical treatment, the employee may pick his or her own provider and assess the costs against the employer. But 287.140 says nothing about the employer waiving its right to select future medical providers, and we are not at liberty to add words to a statute or to ignore the plain meaning of the words chosen by the legislature."

Helmig v. Springfield R-12 Sch. Dist., 688 S.W.3d 315 (Mo. Ct. App. 2024)

Q: Is an ex-spouse considered a dependent under § 287.240?

A: No. Karen Bird is disabled, unemployed, and received Social Security Disability Benefits. She was married to Virgel Bird from 1987 until they divorced in 2019. They continued to live together until Virgel Bird died in an accident arising out of and in the course of his employment.

After the divorce and while living together, the Bird's maintained a joint bank account from which their bills were paid. Karen Bird never deposited money into that account. Following Virgel Bird's death, Karen Bird filed a claim for death benefits alleging that she was her Ex-husbands dependent. The Commission denied the petition. Bird timely appealed.

In denying Karen Bird's argument that she is a dependent, the quote highlights the specific section for which she argues. Under § 287.240.3 The word "dependent" as used in this chapter shall mean:

> (a) A wife upon a husband with whom she lives or who is legally liable for her support, and a husband upon a wife with whom he lives or who is legally liable for his support; …
>
> (b) A natural, posthumous, or adopted child or children, whether legitimate or illegitimate, including any stepchild claimable by the deceased on his or her federal tax return at the time of injury, under the age of eighteen years, or over that age if physically or mentally incapacitated from wage earning, upon the parent legally liable for the support or with whom he, she, or they are living at the time of the death of the parent. …*In all other cases questions of the degree of dependency shall be determined in accordance with the facts at the time of the injury, and in such other cases if there is more than one person wholly dependent the death benefit shall be divided equally among them*.

In denying her appeal, the Court of Appeals highlights specific points. First, Karen argued that the reference to "In all other cases questions of the degree of dependency…" creates a catch-all condition for *all* cases where a person is dependent upon the decedent. The Court concluded that Karen's argument had no merit because she was reading this clause in isolation, ignoring the sentences before it and the clause that follows it. Moreover, the reference to "In all other cases" refers to cases where the degree of dependency between a child or spouse and the decedent is not outlined in the previous sentences. Additionally, the "in all other cases" sentence describes how to determine the degree of dependency and how to divide death benefits in cases other than those involving a dependent incapacitated spouse and dependent children. It says nothing about creating a new class of dependents.

Bird v. US Assets Recovery, LLC, 680 S.W.3d 574 (Mo. Ct. App. 2023)

Q: Is a volunteer firefighter automatically entitled to the statutory minimum of $40.00/week for PPD and TTD?

A: No. Russell Hayes worked as a volunteer firefighter for several decades. In 2018, he was fatally injured while transporting a fire engine for his employer. Susan Hayes, his wife, was awarded the minimum $40/week in benefits for the death of her husband, Russell. The only witnesses to testify at the hearing were Susan Hayes and her expert witnesses, Lieutenant Zinanni and career firefighter Phillip Eldred. The only dispute is about the benefits she was awarded.

Susan Hayes testified about the nominal amounts that Russell Hayes was paid as a volunteer firefighter. Lieutenant Zinanni testified about the level of compensation Russell Hayes would have received had he been employed as a career firefighter. Finally, Phillip Eldred testified regarding wage data for firefighters, generally, including the mean salaries for full-time firefighters nationally, within Missouri, and within southwest Missouri nonmetropolitan areas.

The Administrative Law Judge concluded that Russell Hayes' wage could not be determined pursuant to § 287.250.1(6). Additionally, the ALJ felt that Susan Hayes failed to present evidence to facilitate a calculation under the section. In comparing *Johnson v. City of Duenweg Fire Dept.*, to the present facts, the ALJ concluded the pay of a neighboring full-time firefighter is not indicative of the pay of a volunteer firefighter. Therefore, the Commission affirmed.

On appeal, Susan Hayes argued the Commission erred in finding there was no evidence in the record that the services Mr. Hayes provided as a volunteer firefighter were like the services provided by full-time career firefighters. The Court of Appeals agreed, noting the plain language under § 287.250.1(6) simply requires that the appropriate wage shall be the "usual wage for similar services" provided by paid employees of any employer.

Susan Hayes introduced evidence on the average wage of career firefighters in the State of Missouri and in southwestern Missouri rural fire departments. The Commission did not then compare the services provided by such firefighters to the services provided by Russell Hayes as a volunteer firefighter to determine whether those services are "similar" as is required by § 287.250.1(6).

The Court of Appeals noted that the Commission failed to make the appropriate credibility determinations regarding the testimony of Ms. Hayes, Lieutenant Zinanni, and Phillip Eldred. Therefore, the Court of Appeals remanded the case back to the Commission to determine whether a wage for the purpose of calculating compensation in the form of the "usual wage for similar services" can be determined under § 287.250.1(6).

Dependent of Hayes, 681 S.W.3d 744 (Mo. Ct. App. 2024)

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 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: 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: 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: 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*, 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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